POC Reports User Guide

POC Reports User Guide

Version : 22

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Chapter 1 Introduction

1.1 Attestation Disclaimer

Promoting Interoperability Program attestation confirms the use of a certified Electronic Health Record (EHR) to regulatory standards over a specified period of time. TruBridge Promoting Interoperability Program certified products, recommended processes, and supporting documentation are based on TruBridge's interpretation of the Promoting Interoperability Program regulations, technical specifications, and vendor specifications provided by CMS, ONC, and NIST. Each client is solely responsible for its attestation being a complete and accurate reflection of its EHR use during the attestation period and that any records needed to defend the attestation in an audit are maintained. With the exception of vendor documentation that may be required in support of a client's attestation, TruBridges bear no responsibility for attestation information submitted by the client.

1.2 What's New

This section introduces new features and improvements for **POC Reports** for release Version 20. A brief summary of each enhancement is given referencing its particular location if applicable. As new branches of Version 20 are made available, the original enhancements will be moved to the Previous Work Requests section. The enhancements related to the most current branch available will be listed under the main What's New section.

Each enhancement includes the Work Request (WR) Number and the description. If further information is needed, please contact **Client Services** Support.

Ability to Flag Nursing Orders to Pull to Discharge Instructions and Discharge Summary Reports - WR 1903010755

DESCRIPTION: Nursing Orders may now display on Discharge Instructions and Discharge Summary Reports.

DOCUMENTATION: See Discharge Instructions 52 and Discharge Summary 60 Description and Usage sections.

Floor Stock Report Launches Charging Application - WR 1711060905

DESCRIPTION: When the POC Floorstock Report is selected from the Virtual Chart, the Charging Review screen is launched. From the Charge Review screen, users can select Patient Account Detail Report.

DOCUMENTATION: See Patient Account Detail Report - Floor Stock Report 129

Mean Arterial Pressure Added to Several POC Reports

DESCRIPTION: Mean Arterial Pressure (MAP) has been added to **Patient Progress Notes**, **24 Hour Summary,** and will update to the **Swan Ganz** report without need for cardiac output to be documented.

DOCUMENTATION: See **24 Hour Summary** Description and Usage 7, **Patient Progress Notes** Description and Usage 138 and **Swan Ganz** Description and Usage 188.

Nursing Order Expansion -- WR 1701100942

DESCRIPTION: Nursing Order description categories have been increased to display up to three lines of 225 characters.

DOCUMENTATION: See Nursing Order Report 117, Patient Summary 153, 24 Hour Summary 7, Problem Activity Report, 178 and Patient Census and 130 Patient Progress Notes 138.

Super Amend Behavior Control for Updated EMAR - WR 1810081436

DESCRIPTION: If a user has the behavior control "**Amend MAR Documentation for Any Login",** any super amended documentation performed in the **Updated EMAR** will display on Patient Progress Notes along with the date/time and reason.

DOCUMENTATION: See Description and Usage 138 in Patient Progress Notes.

Chapter 2 Overview

The Point of Care application allows Nursing Services personnel to enter information into the System at the patient bedside. The application is designed to automate clerical functions and eliminate the duplicate entry of information into nursing documents. The data recorded at the bedside is on a concurrent (rather than retrospective) basis. This means that data as it is entered, is instantly available throughout the system and is totally integrated with all other applications (lab, pharmacy, radiology, respiratory care, etc.). The reduction in time spent on clerical tasks through automation allows more time to effectively be spent by nurses on clinical care.

NOTE: *When printing a POC Report from an active account, it is defined by a date range spanning from the beginning of the stay through the date and time selected for inclusion in reports and attachments. This allows users to generate reports reflecting the most up-to-date information available. The* ***Printed*** *and* ***Run Date*** *fields within a POC Report denote the date and time the report is printed, providing a timestamp for reference. When printing a POC Report from an account that has purged, it will also maintain a date range, extending from the start of the stay to the last possible date any changes could have been made before purging to clinical history. For a purged account, the* ***Printed*** *and* ***Run Date/Time*** *field displays the date and time of purging, as this marks the final moment any alterations could occur. Once an account is purged, it transitions to a static state, and the last version of the report becomes the permanent record saved.*

NOTE: *Facilities outside of the United States may choose a date format of MMDDYY, DDMMYY or YYMMDD to be used on all date fields in the Point-of-Care Application. Where four-digit dates display, a date format of MMDD, DDMM or MMDD, respectively, will be used. Whichever date format is selected will be reflected in all date fields and column displays throughout the application. A TruBridge representative will need to be contacted in order for the date format to be changed.*

Chapter 3 Point of Care Reports Access

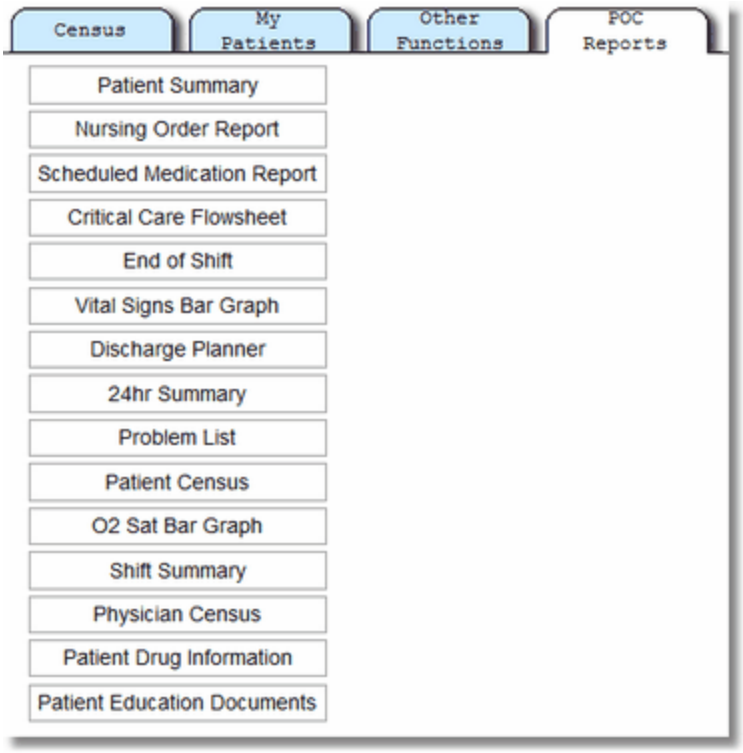
3.1 Overview

This chapter will discuss reports accessible via Point of Care. The reports in this section can be accessed to view/print via Whiteboard, Virtual Chart and/or Printing.

Report Selection

- **POC Whiteboard:** Select the **POC Reports** tab, then the applicable report. Reports selected from the Whiteboard will print directly to the default printer.

In UX, select **System Menu** > **Hospital Base Menu** > **POC Access** > **POC Whiteboard** > **POC Reports**

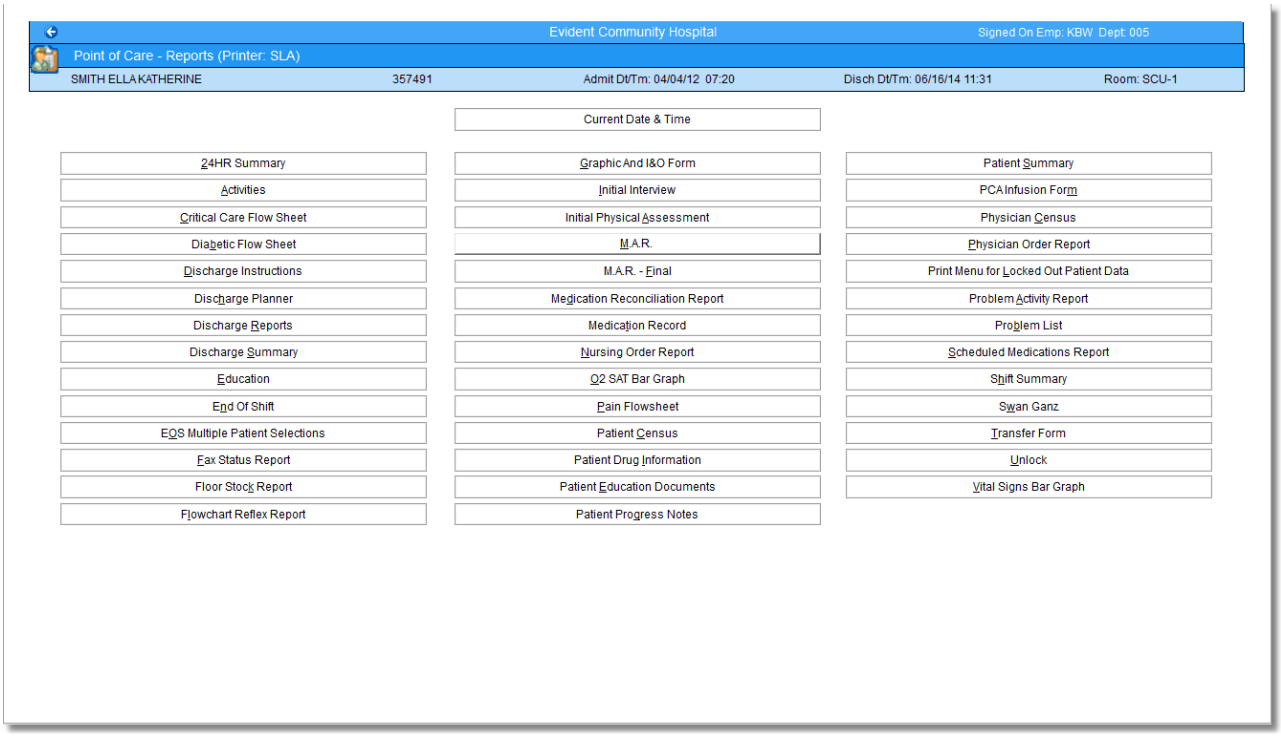


POC Reports

- **Virtual Chart:** Select the report from the applicable tab. Reports selected directly from a Virtual Chart tab will display as a PDF document and may be manually sent to a printer if required.

- **Printing:** Select the **Printing** option via the Virtual Chart or the Chart Menu on Flow Charts to display a list of reports available for selection. Reports generated via the Printing menu will print directly to the default printer.

In UX, select **System Menu** > **Hospital Base Menu** > **POC Access** > **POC Whiteboard** > **Patient** > **Printing**

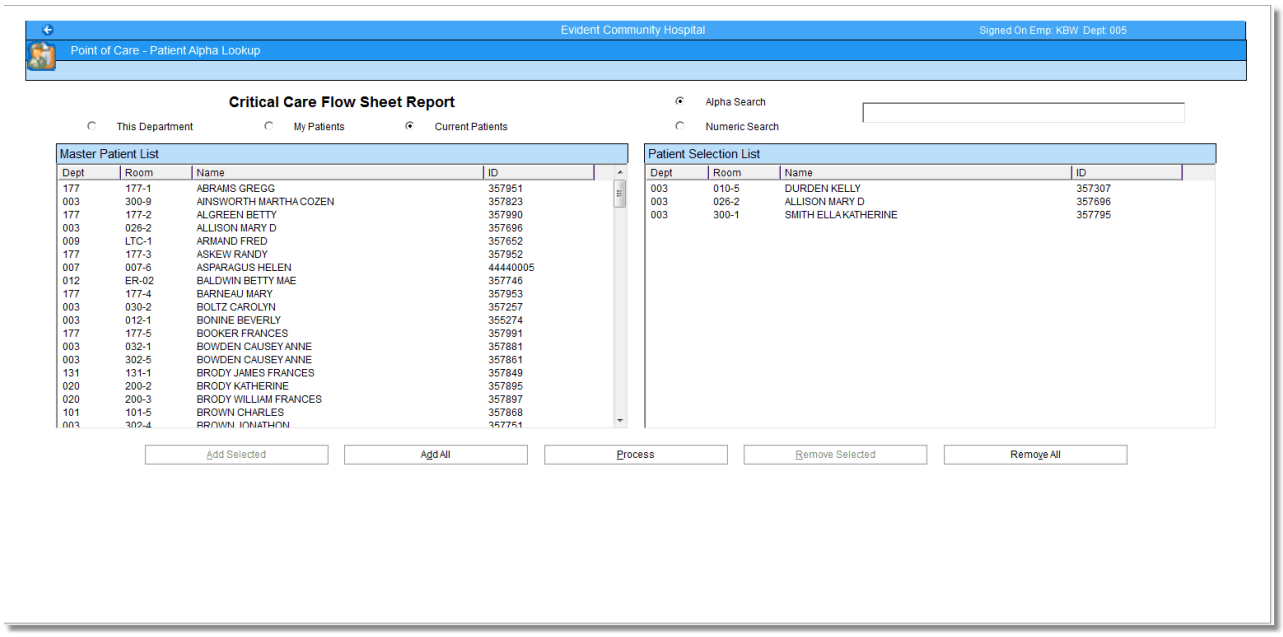


Point of Care - Reports

Multiple Patient Selection

- If multiple patients can be selected when viewing/printing a report, the Point of Care - Patient Alpha Lookup Menu for the selected report displays. Functionality is discussed below.

In UX, select **System Menu** > **Hospital Base Menu** > **POC Access** > **POC Whiteboard** > **POC Reports** > **Critical Care Flow Sheet**



Point of Care - Patient Alpha Look-Up

- Master Patient List: This section lists patients available for selection based on the search option selected.
  - **This Department**: Use this option to display a list of patients registered in the current department.
  - **My Patients**: Use this option to display patients selected as "My Patients".
  - **Current Patients**: This option will display current patients for the entire facility. The **Alpha Search** and **Numeric Search** options are activated when the **Current Patients** option is selected and can be used to narrow the patient search.

- To populate the Patient Selection List, highlight a single or multiple patient name(s) then select **Add Selected**. The entire Master Patient List may be moved to the Patient Selection List by selecting **Add All**. If the report is selected after selecting a patient, the patient's name will immediately populate the Patient Selection List but may be removed before processing.

- To delete a single or multiple patient name(s), highlight the name(s) then select **Remove Selected**. **Remove All** may be selected to completely clear the list.

- Once the Patient Selection List is accurate, select **Process**.

Chapter 4 24 Hour Summary

The 24-Hour Summary (Format A or B) is a document that includes specific patient information charted within the previous 24 hours from the minute it is printed on the system. This report can be printed at any time during the patient's stay, but it is primarily printed at end of shift and for physician rounds. It is an optional report, unless otherwise specified by hospital policy. It is usually not a permanent part of the patient's chart and therefore can be discarded after use.

4.1 How to Print

The 24-Hour Summary may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart, select the appropriate tab.
3. Select **24hr Summary**.
4. Choose from the two available options: **Patient** or **Physician**. The **Patient** option allows the user to choose specified patient(s), and the **Physician** option allows the user to select patients by their attending physician.

The 24-Hour Summary may be set to print to a specified printer automatically at a specific hour or with the end-of-shift reports.

Q. WHAT ARE THE SETUP OPTIONS FOR PRINTING?
A. The 24-Hour Summary (Format A or B) can be set up to print:

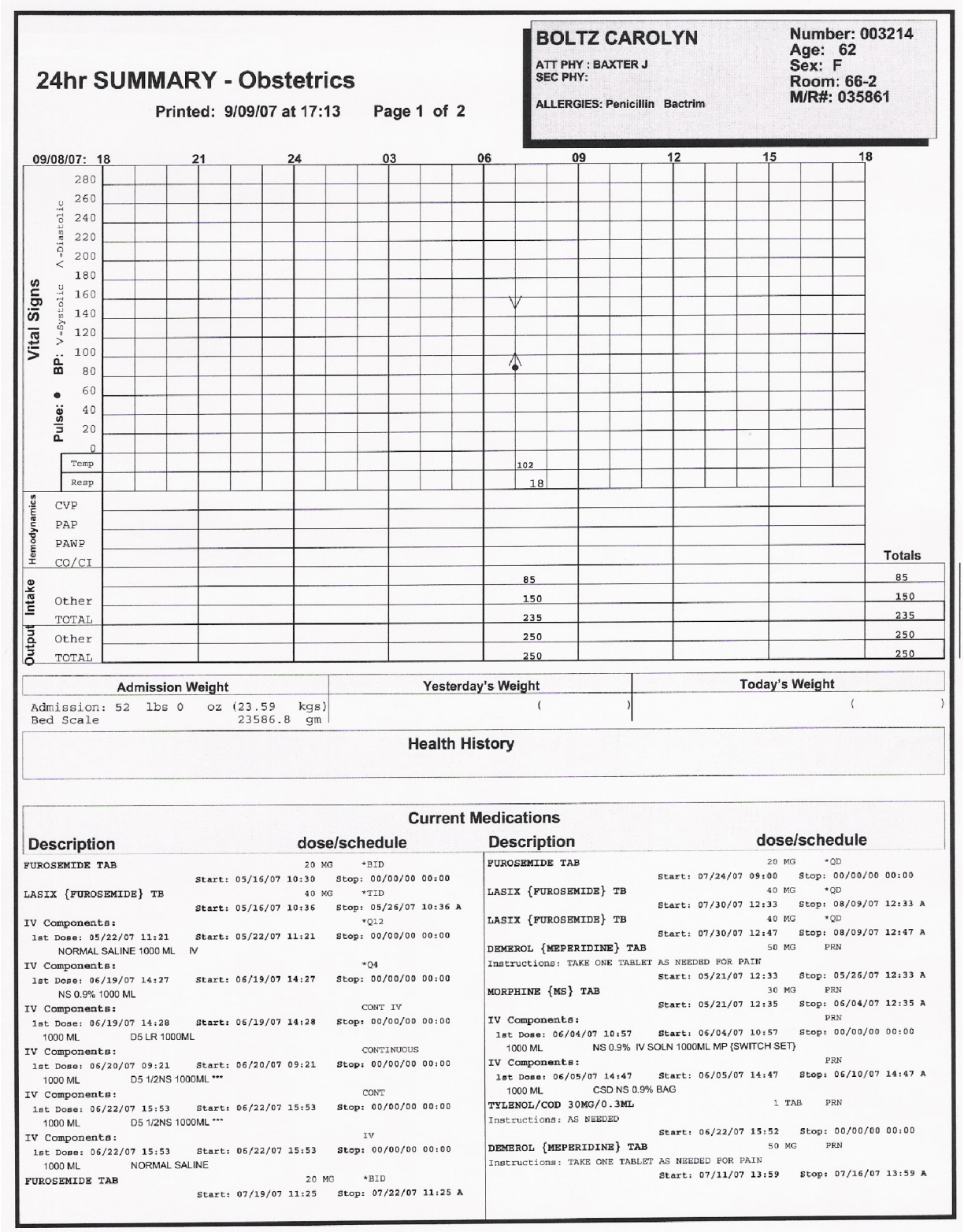
- As part of end-of-shift reports
- Automatically to a specific printer at a specific hour

Setup is completed in the Department Control Table for Point of Care, which can be accessed from the **Hospital Base Menu** > **Nursing Administration Department** > **Master Selection** > **Business Office Tables** > **Business Office Table Maintenance** > **POC Departments**. The code for this report is **24HS**.

4.2 Description and Usage

The 24-Hour Summary (Format A or B) is a document that includes specific patient information charted within the previous 24 hours from the minute it is printed on the system. This worksheet provides both nurses and physicians details of the patient’s condition and plan of care. It is one of the primary tools used by nursing to conduct an organized and timely shift change. It is one of the reports preferred reports by physicians to use as reference while making rounds.

24hr Summary - Format A - Page 1 of 1



BOLTZ CAROLYN
ATT PHY : BAXTER J
SEC PHY:
ALLERGIES: Penicillin Bactrim

Number: 003214
Age: 62
Sex: F
Room: 66-2
M/R#: 035861

24hr SUMMARY - Obstetrics

Printed: 9/09/07 at 17:13 Page 1 of 2

09/08/07: 18 21 24 03 06 09 12 15 18

Vital Signs — BP: V=Systolic ^=Diastolic — Pulse: ●
280 260 240 220 200 180 160 140 120 100 80 60 40 20 0
Temp 102
Resp 18

		Totals
Hemodynamics	CVP	
	PAP	
	PAWP	
	CO/CI	
Intake	Other	85
	TOTAL	150
		235
Output	Other	250
	TOTAL	250

Admission Weight	Yesterday's Weight	Today's Weight
Admission: 52 lbs 0 oz (23.59 kgs) Bed Scale 23586.8 gm	( )	( )

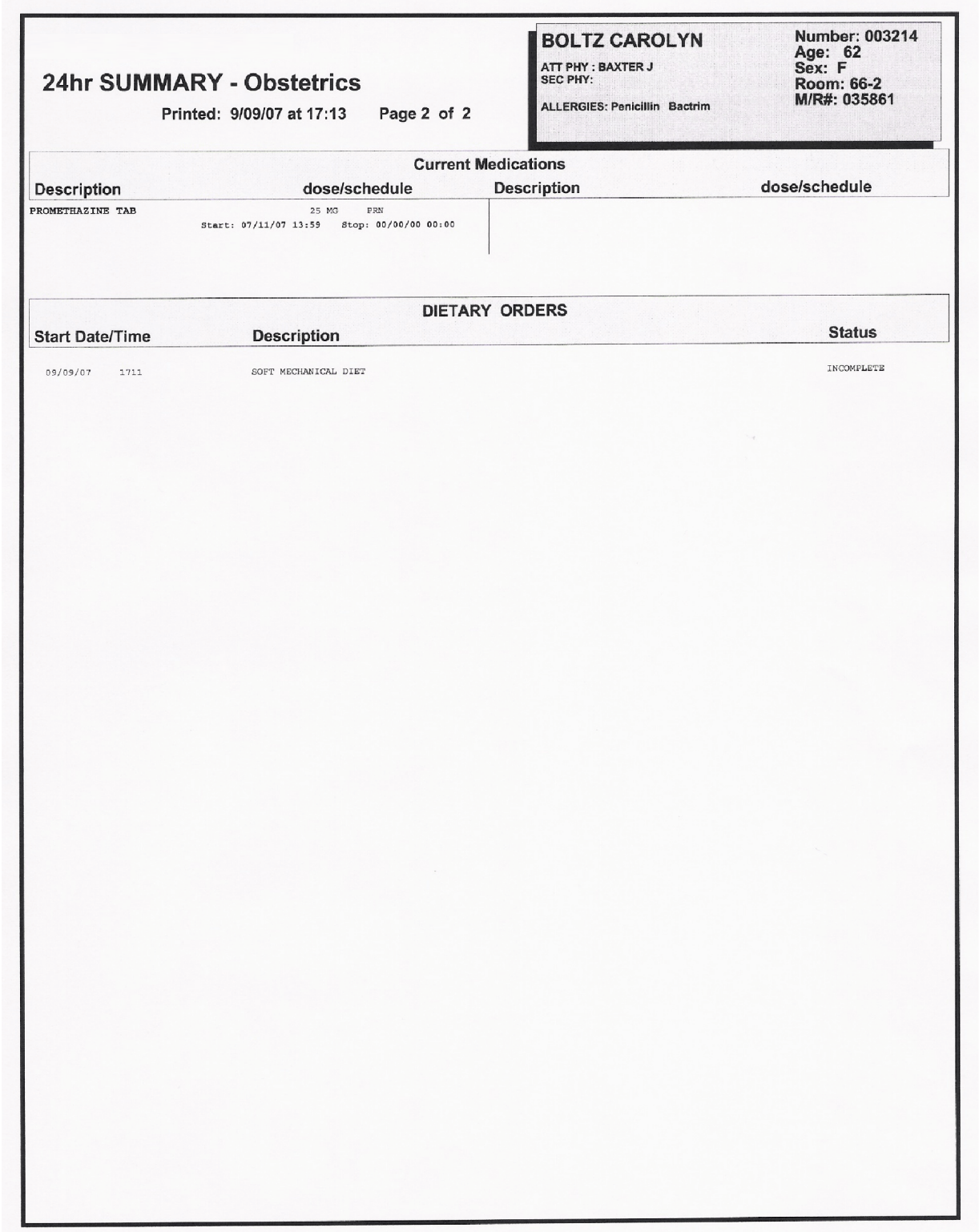
Health History

Current Medications

Description	dose/schedule
FUROSEMIDE TAB	20 MG *BID Start: 05/16/07 10:30 Stop: 00/00/00 00:00
LASIX {FUROSEMIDE} TB	40 MG *TID Start: 05/16/07 10:36 Stop: 05/26/07 10:36 A
IV Components:	*Q12 1st Dose: 05/22/07 11:21 Start: 05/22/07 11:21 Stop: 00/00/00 00:00 NORMAL SALINE 1000 ML IV
IV Components:	*Q4 1st Dose: 06/19/07 14:27 Start: 06/19/07 14:27 Stop: 00/00/00 00:00 NS 0.9% 1000 ML
IV Components:	CONT IV 1st Dose: 06/19/07 14:28 Start: 06/19/07 14:28 Stop: 00/00/00 00:00 1000 ML D5 LR 1000ML
IV Components:	CONTINUOUS 1st Dose: 06/20/07 09:21 Start: 06/20/07 09:21 Stop: 00/00/00 00:00 1000 ML D5 1/2NS 1000ML ***
IV Components:	CONT 1st Dose: 06/22/07 15:53 Start: 06/22/07 15:53 Stop: 00/00/00 00:00 1000 ML D5 1/2NS 1000ML ***
IV Components:	IV 1st Dose: 06/22/07 15:53 Start: 06/22/07 15:53 Stop: 00/00/00 00:00 1000 ML NORMAL SALINE
FUROSEMIDE TAB	20 MG *BID Start: 07/19/07 11:25 Stop: 07/22/07 11:25 A

Description	dose/schedule
FUROSEMIDE TAB	20 MG *QD Start: 07/24/07 09:00 Stop: 00/00/00 00:00
LASIX {FUROSEMIDE} TB	40 MG *QD Start: 07/30/07 12:33 Stop: 08/09/07 12:33 A
LASIX {FUROSEMIDE} TB	40 MG *QD Start: 07/30/07 12:47 Stop: 08/09/07 12:47 A
DEMEROL {MEPERIDINE} TAB	50 MG PRN Instructions: TAKE ONE TABLET AS NEEDED FOR PAIN Start: 05/21/07 12:33 Stop: 05/26/07 12:33 A
MORPHINE {MS} TAB	30 MG PRN Start: 05/21/07 12:35 Stop: 06/04/07 12:35 A
IV Components:	PRN 1st Dose: 06/04/07 10:57 Start: 06/04/07 10:57 Stop: 00/00/00 00:00 1000 ML NS 0.9% IV SOLN 1000ML MP {SWITCH SET}
IV Components:	PRN 1st Dose: 06/05/07 14:47 Start: 06/05/07 14:47 Stop: 06/10/07 14:47 A 1000 ML CSD NS 0.9% BAG
TYLENOL/COD 30MG/0.3ML	1 TAB PRN Instructions: AS NEEDED Start: 06/22/07 15:52 Stop: 00/00/00 00:00
DEMEROL {MEPERIDINE} TAB	50 MG PRN Instructions: TAKE ONE TABLET AS NEEDED FOR PAIN Start: 07/11/07 13:59 Stop: 07/16/07 13:59 A

24hr Summary - Format A - Page 2 of 2



24hr SUMMARY - Obstetrics

Printed: 9/09/07 at 17:13 Page 2 of 2

BOLTZ CAROLYN
ATT PHY : BAXTER J
SEC PHY:
ALLERGIES: Penicillin Bactrim

Number: 003214
Age: 62
Sex: F
Room: 66-2
M/R#: 035861

Current Medications

Description	dose/schedule	Description	dose/schedule
PROMETHAZINE TAB	25 MG PRN Start: 07/11/07 13:59 Stop: 00/00/00 00:00		

DIETARY ORDERS

Start Date/Time	Description	Status
09/09/07 1711	SOFT MECHANICAL DIET	INCOMPLETE

- **Demographics Box (upper-right corner):** This will include the patient's name, visit number, admitting and/or second physician, age, sex, room number, medical record number, and drug allergies documented through the TruBridge EHR system.

- **Vital Signs:** Pulse and blood pressure, displayed either graphically or numerically in one hour intervals. Mean Arterial Pressure (MAP) will calculate and display with the blood pressure documented. Temperature and respirations are displayed numerically in one hour intervals.

- **Hemodynamics (Optional):** CVP, PAP, PAWP, and CO/CI values are displayed in three hour intervals. In order for this information to be included, it must be set up by Nursing Administration.

- **O2/Ventilation Information:** The user determines which seven of twelve options will be included. Values display in three-hour intervals.

  NOTE: *An asterisk (*) adjacent to any value on this report indicates multiple values have been charted within the specified time frame. The last recorded value is printed. Preceding values are available on-line or in Patient Progress Notes.*

- **Intake:** The user determines which seven of twelve options will be included. Values display in three hour intervals. The "OTHER" box combines all intake values not specified on the report. These details are available on-line or in the Patient Progress Notes. For Pediatric/Nursery chart types, an option to record breast feeding will appear.

- **Output:** The user determines which four out of 18 options will be included. Values display in three hour intervals. The "OTHER" box combines all output values not specified on the report. These details are available on-line or in the Patient Progress Notes. Entries charted by frequency print in the top left corner of each box.

- **Weight:** Admission weight is printed in both pounds and kilograms. Yesterday's weight in pounds and kilograms, with date and time charted is printed. Today's weight in pounds and kilograms, with date and time charted is printed.

- **Diet:** Includes the following information charted through MEDACT for the 24 hour period prior to the printing of the report:
  - Date and time the information was charted
  - Diet, along with the date and time it was scheduled to begin.
  - Any comments entered
  - Percent consumed
  - Start date/time, description, and status of the diet order will also display under the heading Dietary Orders.

- **Current Medications (Optional):** Includes all active medications at the time the report is printed. Medication description, dose, frequency, and auto stop date if applicable. Can include future dated medication orders. This feature is controlled by a switch in the 24HR Summary setup. Does not include discontinued medications. In order for this information to be included, it must be set up by Nursing Administration.

- **Administered Medications (Optional):** Lists all medications administered during the previous 24 hours along with the date and time of last administration. If a medication is administered outside of the 30 minute window prior to or after administration time, the system can be set to flag the administration with a “Check” time. This feature is controlled by a switch in the Point of Care Control Record in the Nursing Administration Department. It can also reflect the medication description, location of administration, reason for PRN administration and dosage. In order for this information to be reflected, it must be set up by Nursing Administration.

- **Flagged Abnormals (Optional):** Displays the name of procedure in reverse chronological order. Flagged abnormal lab results, are results flagged with a L (low), LC (low critical), H (high) or HC (high critical) value.

- **Omitted Medications (Optional):** Lists all medications omitted in the previous twenty-four hours along with the medication description, omission date and time or check time, reason for omission, and includes discontinued medications. In order for this information to be included, it must be set up by Nursing Administration.

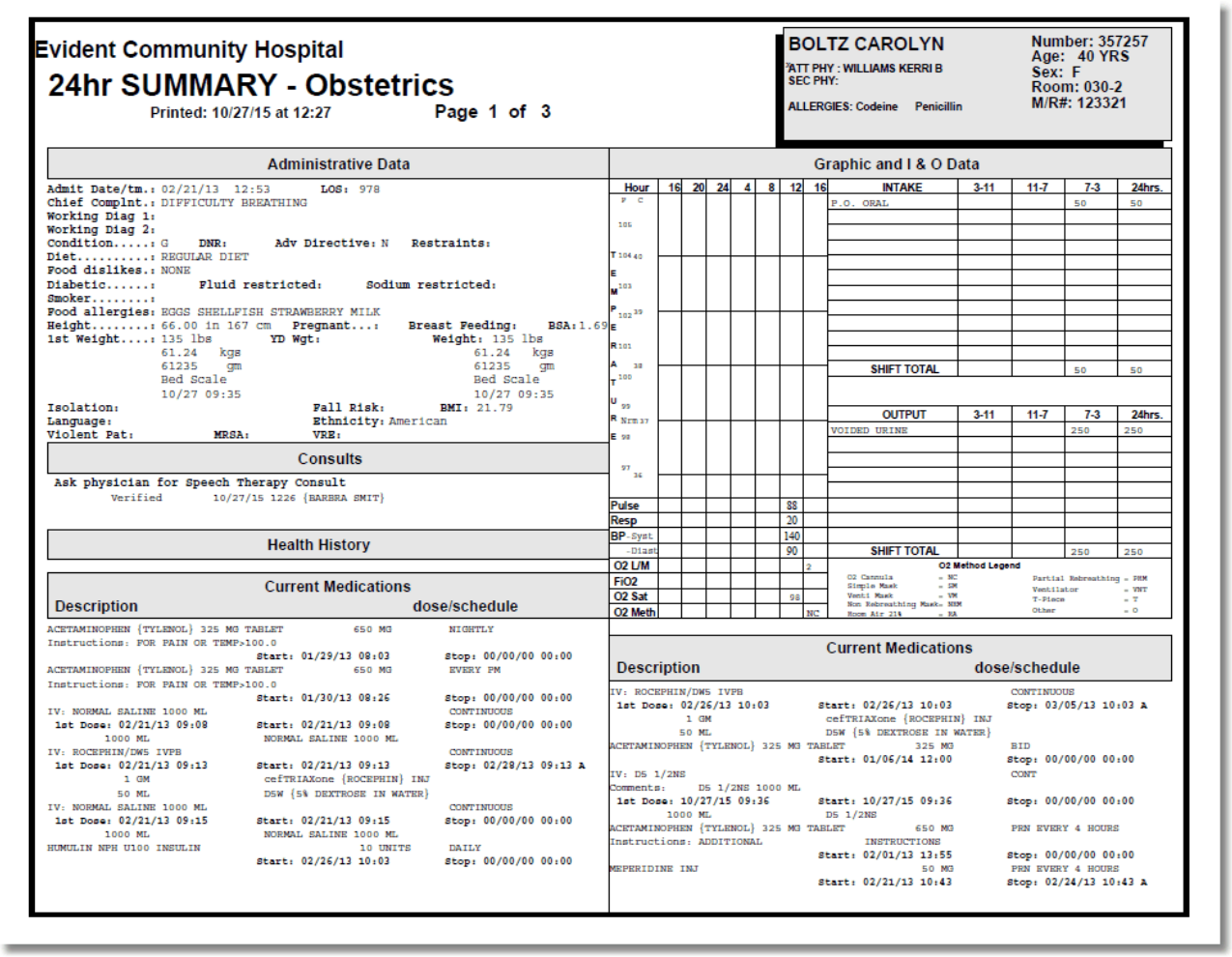
- **Neuro Checks (Optional):** Lists neuro checks charted through the VS application during the previous 24 hour period. Will display the date and time information was entered and the name and title of person who charted the entry.

- **X1 {one-time} and PRN Medications (Optional):** Lists all X1 & PRN administrations in the previous 24 hour period. Displays medication description, quantity, frequency and time of administration, and a reason for PRN medications. It does not include discontinued medications. In order for this information to be reflected, it must be set up by Nursing Administration.

- **Blood Glucose Readings (Optional):** Includes all administrations in the previous 24 hour period. Displays date and time entry was charted, blood sugar level, description of medication given (sliding scale insulin only), unit(s) of medication given and frequency, and any other interventions charted. In order for this information to be reflected, it must be set up by Nursing Administration.

- **Immunizations:** Lists immunizations and the dates they were received

24hr Summary - Format B - Page 1 of 3



Evident Community Hospital

24hr SUMMARY - Obstetrics

Printed: 10/27/15 at 12:27 Page 1 of 3

BOLTZ CAROLYN
ATT PHY : WILLIAMS KERRI B
SEC PHY:
ALLERGIES: Codeine Penicillin

Number: 357257
Age: 40 YRS
Sex: F
Room: 030-2
M/R#: 123321

Administrative Data

Admit Date/tm.: 02/21/13 12:53 LOS: 978
Chief Complnt.: DIFFICULTY BREATHING
Working Diag 1:
Working Diag 2:
Condition.....: G DNR: Adv Directive: N Restraints:
Diet.....: REGULAR DIET
Food dislikes.: NONE
Diabetic.....: Fluid restricted: Sodium restricted:
Smoker.....:
Food allergies: EGGS SHELLFISH STRAWBERRY MILK
Height.....: 66.00 in 167 cm Pregnant...: Breast Feeding: BSA:1.69
1st Weight....: 135 lbs YD Wgt: Weight: 135 lbs
61.24 kgs 61.24 kgs
61235 gm 61235 gm
Bed Scale Bed Scale
10/27 09:35 10/27 09:35
Isolation: Fall Risk: BMI: 21.79
Language: Ethnicity: American
Violent Pat: MRSA: VRE:

Consults

Ask physician for Speech Therapy Consult
Verified 10/27/15 1226 {BARBRA SMIT}

Health History

Current Medications

Description	dose/schedule
ACETAMINOPHEN {TYLENOL} 325 MG TABLET	650 MG NIGHTLY
Instructions: FOR PAIN OR TEMP>100.0	
	Start: 01/29/13 08:03 Stop: 00/00/00 00:00
ACETAMINOPHEN {TYLENOL} 325 MG TABLET	650 MG EVERY PM
Instructions: FOR PAIN OR TEMP>100.0	
	Start: 01/30/13 08:26 Stop: 00/00/00 00:00
IV: NORMAL SALINE 1000 ML	CONTINUOUS
1st Dose: 02/21/13 09:08	Start: 02/21/13 09:08 Stop: 00/00/00 00:00
1000 ML	NORMAL SALINE 1000 ML
IV: ROCEPHIN/DW5 IVPB	CONTINUOUS
1st Dose: 02/21/13 09:13	Start: 02/21/13 09:13 Stop: 02/28/13 09:13 A
1 GM	ceftRIAXone {ROCEPHIN} INJ
50 ML	DSW {5% DEXTROSE IN WATER}
IV: NORMAL SALINE 1000 ML	CONTINUOUS
1st Dose: 02/21/13 09:15	Start: 02/21/13 09:15 Stop: 00/00/00 00:00
1000 ML	NORMAL SALINE 1000 ML
HUMULIN NPH U100 INSULIN	10 UNITS DAILY
	Start: 02/26/13 10:03 Stop: 00/00/00 00:00

Graphic and I & O Data

Hour	16	20	24	4	8	12	16
Pulse						88	
Resp						20	
BP Syst						140	
Diast						90	
O2 L/M							2
FiO2							
O2 Sat						98	
O2 Meth							NC

INTAKE	3-11	11-7	7-3	24hrs.
P.O. ORAL			50	50
SHIFT TOTAL			50	50

OUTPUT	3-11	11-7	7-3	24hrs.
VOIDED URINE			250	250
SHIFT TOTAL			250	250

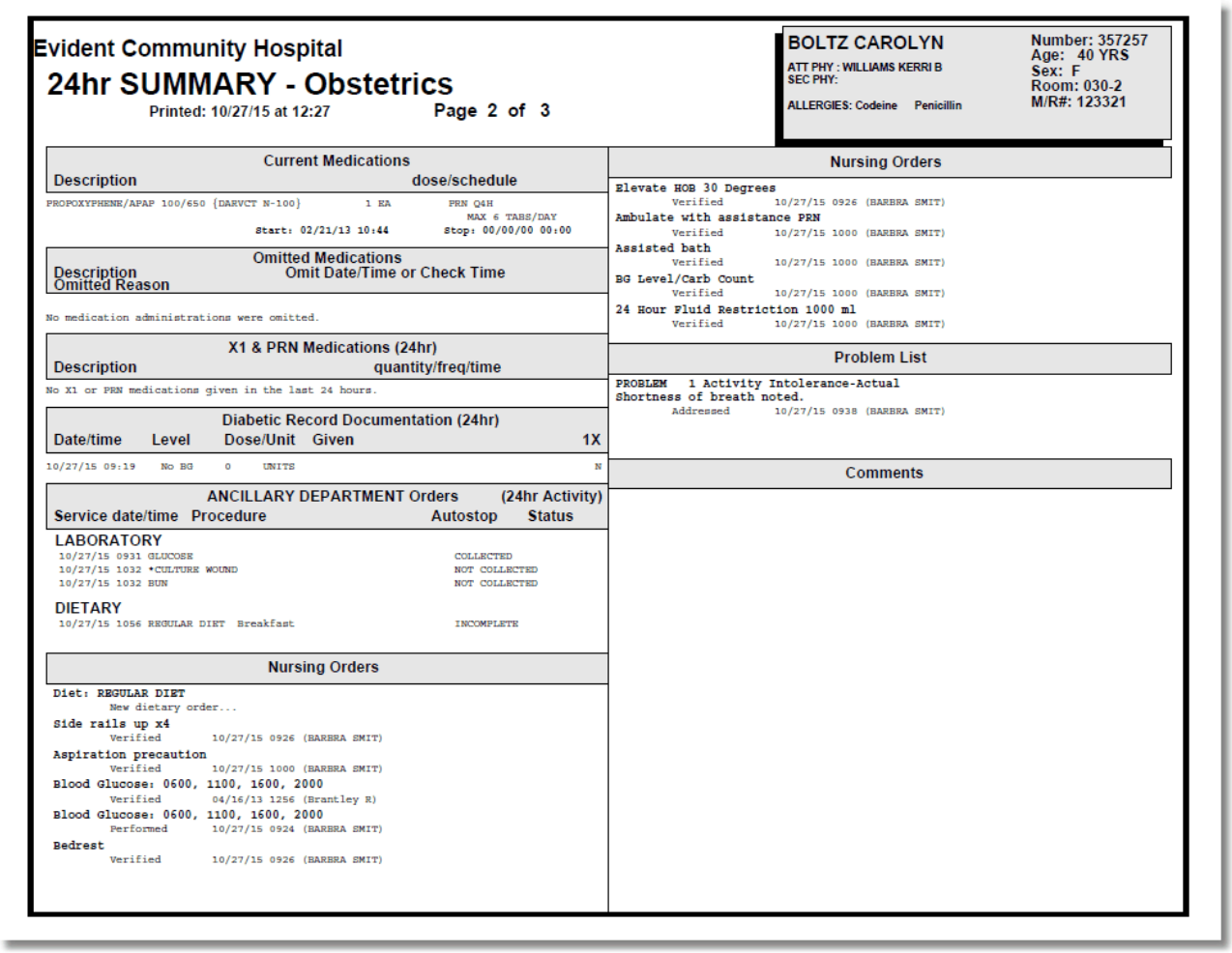
O2 Method Legend

O2 Cannula	= NC	Partial Rebreathing	= PRM
Simple Mask	= SM	Ventilator	= VNT
Venti Mask	= VM	T-Piece	= T
Non Rebreathing Mask	= NRM	Other	= O
Room Air 21%	= RA		

Current Medications

Description	dose/schedule
IV: ROCEPHIN/DW5 IVPB	CONTINUOUS
1st Dose: 02/26/13 10:03	Start: 02/26/13 10:03 Stop: 03/05/13 10:03 A
1 GM	ceftRIAXone {ROCEPHIN} INJ
50 ML	DSW {5% DEXTROSE IN WATER}
ACETAMINOPHEN {TYLENOL} 325 MG TABLET	325 MG BID
	Start: 01/06/14 12:00 Stop: 00/00/00 00:00
IV: D5 1/2NS	CONT
Comments: D5 1/2NS 1000 ML	
1st Dose: 10/27/15 09:36	Start: 10/27/15 09:36 Stop: 00/00/00 00:00
1000 ML	D5 1/2NS
ACETAMINOPHEN {TYLENOL} 325 MG TABLET	650 MG PRN EVERY 4 HOURS
Instructions: ADDITIONAL	INSTRUCTIONS
	Start: 02/01/13 13:55 Stop: 00/00/00 00:00
MEPERIDINE INJ	50 MG PRN EVERY 4 HOURS
	Start: 02/21/13 10:43 Stop: 02/24/13 10:43 A

24hr Summary - Format B - Page 2 of 3



Evident Community Hospital

24hr SUMMARY - Obstetrics

Printed: 10/27/15 at 12:27 Page 2 of 3

BOLTZ CAROLYN
ATT PHY : WILLIAMS KERRI B
SEC PHY:
ALLERGIES: Codeine Penicillin

Number: 357257
Age: 40 YRS
Sex: F
Room: 030-2
M/R#: 123321

Current Medications

Description	dose/schedule
PROPOXYPHENE/APAP 100/650 (DARVCT N-100)	1 EA PRN Q4H MAX 6 TABS/DAY
Start: 02/21/13 10:44	Stop: 00/00/00 00:00

Omitted Medications

Description / Omitted Reason — Omit Date/Time or Check Time

No medication administrations were omitted.

X1 & PRN Medications (24hr)

Description — quantity/freq/time

No X1 or PRN medications given in the last 24 hours.

Diabetic Record Documentation (24hr)

Date/time	Level	Dose/Unit	Given	1X
10/27/15 09:19	No BG	0	UNITS	N

ANCILLARY DEPARTMENT Orders (24hr Activity)

Service date/time	Procedure	Autostop	Status
LABORATORY			
10/27/15 0931	GLUCOSE		COLLECTED
10/27/15 1032	*CULTURE WOUND		NOT COLLECTED
10/27/15 1032	BUN		NOT COLLECTED
DIETARY			
10/27/15 1056	REGULAR DIET Breakfast		INCOMPLETE

Nursing Orders

Diet: REGULAR DIET
New dietary order...
Side rails up x4
Verified 10/27/15 0926 (BARBRA SMIT)
Aspiration precaution
Verified 10/27/15 1000 (BARBRA SMIT)
Blood Glucose: 0600, 1100, 1600, 2000
Verified 04/16/13 1256 (Brantley R)
Blood Glucose: 0600, 1100, 1600, 2000
Performed 10/27/15 0924 (BARBRA SMIT)
Bedrest
Verified 10/27/15 0926 (BARBRA SMIT)

Nursing Orders

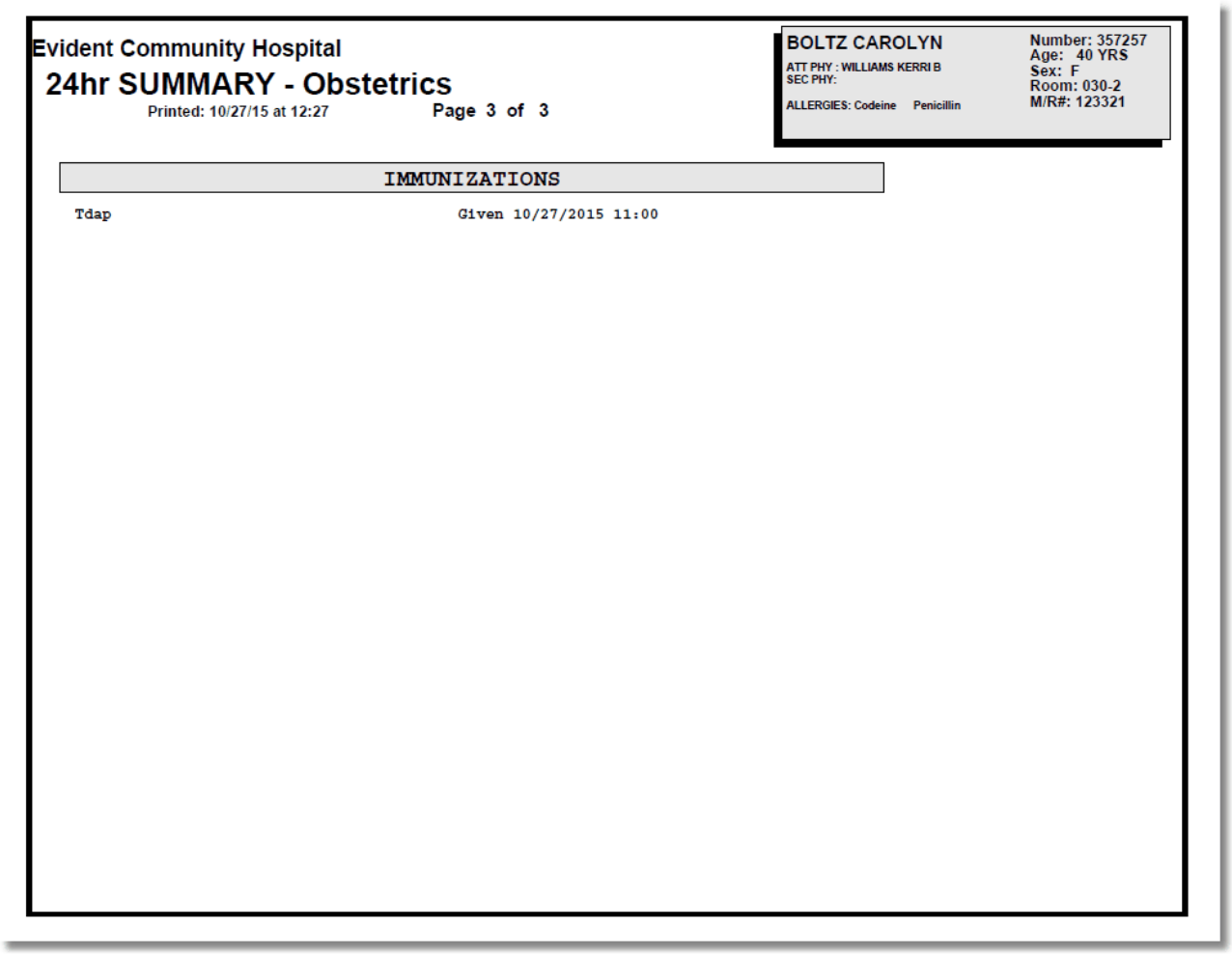
Elevate HOB 30 Degrees
Verified 10/27/15 0926 (BARBRA SMIT)
Ambulate with assistance PRN
Verified 10/27/15 1000 (BARBRA SMIT)
Assisted bath
Verified 10/27/15 1000 (BARBRA SMIT)
BG Level/Carb Count
Verified 10/27/15 1000 (BARBRA SMIT)
24 Hour Fluid Restriction 1000 ml
Verified 10/27/15 1000 (BARBRA SMIT)

Problem List

PROBLEM 1 Activity Intolerance-Actual
Shortness of breath noted.
Addressed 10/27/15 0938 (BARBRA SMIT)

Comments

24hr Summary - Format B - Page 3 of 3



Evident Community Hospital

24hr SUMMARY - Obstetrics

Printed: 10/27/15 at 12:27 Page 3 of 3

BOLTZ CAROLYN
ATT PHY : WILLIAMS KERRI B
SEC PHY:
ALLERGIES: Codeine Penicillin

Number: 357257
Age: 40 YRS
Sex: F
Room: 030-2
M/R#: 123321

IMMUNIZATIONS

Tdap Given 10/27/2015 11:00

- **Demographics Box (located upper right-hand corner):** Includes patient's name, account number, admitting and/or second physician, age, sex, room number, medical record number, and any drug allergies documented through the TruBridge EHR system.

- **Administrative Data (Optional):** In order for the following information to be reflected, it must be set up by Nursing Administration.

  - Admission date and time
  - Length of stay
  - Chief Complnt
  - Working diagnosis 1
  - Working diagnosis 2
  - Condition
  - DNR
  - Adv Directive
  - Restraints
  - Current diet
  - Food dislikes
  - Food allergies
  - Indicators for diabetic status
  - Fluid restriction
  - Sodium restriction
  - Smoker status
  - Height in inches and centimeters
  - If patient is pregnant or breastfeeding
  - Admit weight in pounds and kilograms
  - Yesterday's weight in pounds and kilograms
  - Current weight in pounds and kilograms
  - Admitting condition and body surface area
  - Isolation
  - Fall Risk
  - Language
  - Ethnicity

- **Flagged Abnormals (Optional):** Displays the name of the procedure in reverse chronological order. Flagged abnormal lab results are results flagged with a L (low), LC (low critical), H (high) or HC (high critical) value.

- **Consults (Optional):** Displays the description of the consultation as well as the status of the consultation. In order for this information to be reflected, it must be set up by Nursing Administration.

- **Health History:** Includes patient's health history entered via the Initial Interview.

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- **Current Medications (Optional):** Lists all active medications at the time the report is printed. Will display the medication description, dose, frequency, and auto stop date if applicable. Can include future dated medication orders. This feature is controlled by a switch in the 24HR Summary setup. It does not include discontinued medications. In order for this information to be reflected, it must be set up by Nursing Administration.

- **Omitted Medications (Optional):** Lists all omitted medications in the previous 24 hour period. Will display medication description, omission date and time, or check time, and omission reason. Also includes "Check" time medications. If a medication is administered outside of the 30 minute window prior to or after administration time, the system can be set to flag the administration with "Check". This feature is controlled by a switch in the Point of Care Control Record in the Nursing Administration Department. Will Include discontinued medications as well. In order for this information to be reflected, it must be set up by Nursing Administration.

- **Nursing Orders (Optional):** This section lists Nursing Orders. This area displays three lines of 75 characters each for a total of 225 characters. This applies to Format B.

- **O2 Information:** Displays O2 L/Min, FiO2, and O2 Sat.

- **Immunizations:** Lists immunizations and the dates they were received.

Chapter 5 5 Day M.A.R.-Final

The 5 Day MAR-Final is a document that includes the patient's complete medication administration chart for the previous 5 days. It is optional, unless otherwise specified by hospital policy. The report is usually a permanent part of the patient's chart. For the first four days, a temporary 5 Day MAR will print. A 5 Day MAR - Final will print at the end of the 5th day of the patient's stay.

The 5 Day MAR-Final can be printed at any time during the patient's stay, but should be printed automatically at a specific hour, once a day.

The nursing staff can print the report, but it is usually set up to automatically print at a specific hour. The report runs from midnight to midnight and should be printed before 8am. This will ensure that the correct information is captured on the report.

5.1 How to Print

The 5 Day M.A.R. - Final may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart, select the appropriate tab.
3. Select **5day MAR**.

Q. WHAT ARE THE SETUP OPTIONS FOR PRINTING?

A. The 5 DAY MAR – Final can be set up to print:

- As part of end-of-shift reports
- As part of discharge reports
- Automatically at a specific hour to a specific printer
- At a set interval, spooled to the PC Backup

It can also be set to purge to ADR. If the patient's stay is longer than 5 days, the most recent final will purge.

A. The 5 Day MAR is set up to print for certain stay types.

- Stay type(s) are set up in Point of Care Control Maintenance, which can be accessed from the **Hospital Base Menu** > **Nursing Administration Department** > **Print Reports** > **Point of Care Control Maintenance** (Page 8). In the **Use 5-day MAR?** field, select the check boxes for the appropriate stay types.

- The report can be sorted by one of the following options:
  - N (Name) – The report will print in alphabetical order.
  - C (Class) – The report will print by drug class – antibiotic, coagulant, etc. IVs are unable to print by class since there are multiple fluids and NDC numbers associated with IVs.
  - A – The report will print in chronological order.
  - D – The report will print in reverse chronological order – most recent to first.

Setup for the 5 Day MAR - Final is completed in the Department Control Table for Point of Care, which can be accessed from the **Hospital Base Menu** > **Nursing Administration Department** > **Master Selection** > **Business Office Tables** > **Business Office Table Maintenance** > **POC Departments**. The code for this report is **MAR**.

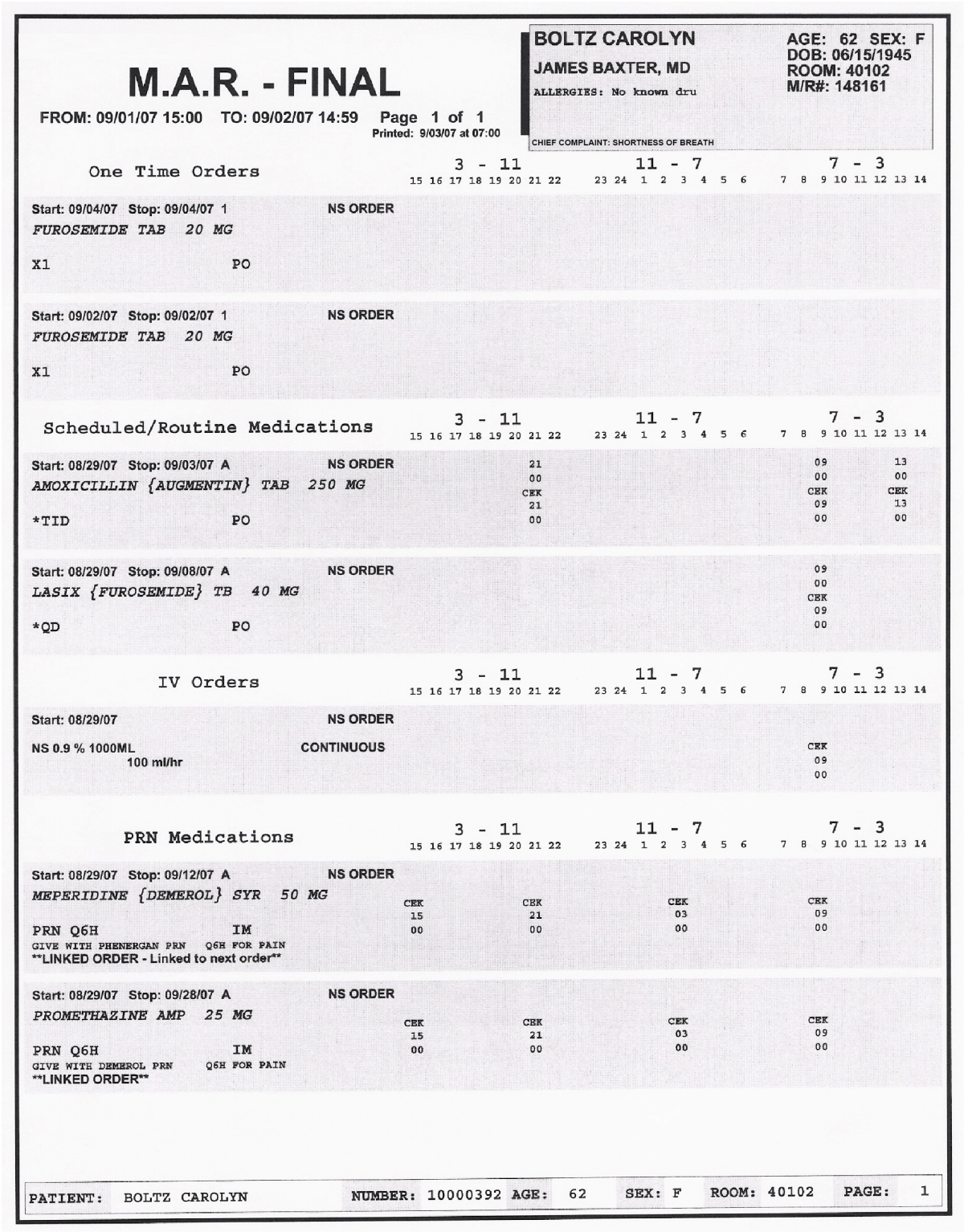
5.2 Description and Usage

The MAR-Final is a document that includes the patient's complete medication administration chart for the previous 5 days. The medications are grouped by categories (X1, Scheduled/Routine, IV orders, PRN, and MISC Pharmacy Charges/Activities and Treatments) and display in the order in that they were entered into the system.

The previous day displays in column form, with the medication administration time(s), the initials of the nurse who administered the medication, and the actual time the medication was administered appearing below, if the medication was given. (The Medication Record that is printed from the Nursing Department, Hospital Base menu-Print Reports-A or the Nursing Department, Patient Functions Screen-Z, does not include the administration time(s) and the initials of the nurse who administered the medication.)

The Point of Care 5 DAY MAR takes the place of the Medication Record.

Final MAR - Page 1 of 1



M.A.R. - FINAL

FROM: 09/01/07 15:00 TO: 09/02/07 14:59 Page 1 of 1
Printed: 9/03/07 at 07:00

BOLTZ CAROLYN
JAMES BAXTER, MD
ALLERGIES: No known dru
CHIEF COMPLAINT: SHORTNESS OF BREATH

AGE: 62 SEX: F
DOB: 06/15/1945
ROOM: 40102
M/R#: 148161

One Time Orders

		3 - 11 (15 16 17 18 19 20 21 22)	11 - 7 (23 24 1 2 3 4 5 6)	7 - 3 (7 8 9 10 11 12 13 14)
Start: 09/04/07 Stop: 09/04/07 1 NS ORDER *FUROSEMIDE TAB 20 MG* X1 PO				
Start: 09/02/07 Stop: 09/02/07 1 NS ORDER *FUROSEMIDE TAB 20 MG* X1 PO				

Scheduled/Routine Medications

		3 - 11 (15 16 17 18 19 20 21 22)	11 - 7 (23 24 1 2 3 4 5 6)	7 - 3 (7 8 9 10 11 12 13 14)
Start: 08/29/07 Stop: 09/03/07 A NS ORDER *AMOXICILLIN {AUGMENTIN} TAB 250 MG* *TID PO		21 00 CEK 21 00		09 00 CEK 09 00 13 00 CEK 13 00
Start: 08/29/07 Stop: 09/08/07 A NS ORDER *LASIX {FUROSEMIDE} TB 40 MG* *QD PO				09 00 CEK 09 00

IV Orders

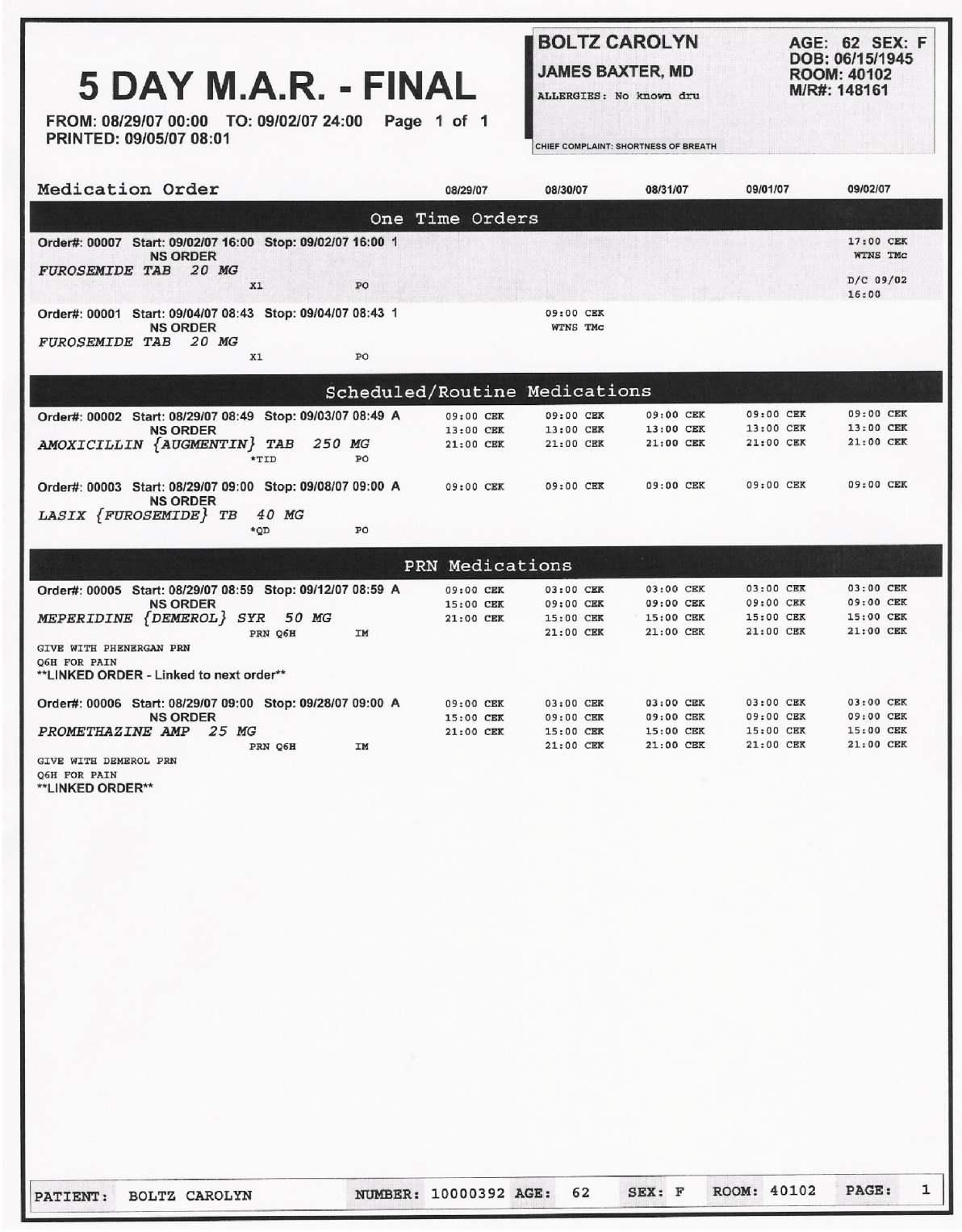
		3 - 11 (15 16 17 18 19 20 21 22)	11 - 7 (23 24 1 2 3 4 5 6)	7 - 3 (7 8 9 10 11 12 13 14)
Start: 08/29/07 NS ORDER NS 0.9 % 1000ML CONTINUOUS 100 ml/hr				CEK 09 00

PRN Medications

		3 - 11 (15 16 17 18 19 20 21 22)	11 - 7 (23 24 1 2 3 4 5 6)	7 - 3 (7 8 9 10 11 12 13 14)
Start: 08/29/07 Stop: 09/12/07 A NS ORDER *MEPERIDINE {DEMEROL} SYR 50 MG* PRN Q6H IM GIVE WITH PHENERGAN PRN Q6H FOR PAIN **LINKED ORDER - Linked to next order**	CEK 15 00	CEK 21 00	CEK 03 00	CEK 09 00
Start: 08/29/07 Stop: 09/28/07 A NS ORDER *PROMETHAZINE AMP 25 MG* PRN Q6H IM GIVE WITH DEMEROL PRN Q6H FOR PAIN **LINKED ORDER**	CEK 15 00	CEK 21 00	CEK 03 00	CEK 09 00

PATIENT: BOLTZ CAROLYN NUMBER: 10000392 AGE: 62 SEX: F ROOM: 40102 PAGE: 1

Final 5 Day MAR - Page 1 of 1



5 DAY M.A.R. - FINAL

FROM: 08/29/07 00:00 TO: 09/02/07 24:00 Page 1 of 1
PRINTED: 09/05/07 08:01

BOLTZ CAROLYN
JAMES BAXTER, MD
ALLERGIES: No known dru
AGE: 62 SEX: F
DOB: 06/15/1945
ROOM: 40102
M/R#: 148161
CHIEF COMPLAINT: SHORTNESS OF BREATH

Medication Order	08/29/07	08/30/07	08/31/07	09/01/07	09/02/07
One Time Orders					
Order#: 00007 Start: 09/02/07 16:00 Stop: 09/02/07 16:00 1 NS ORDER *FUROSEMIDE TAB 20 MG* X1 PO					17:00 CEK WTNS TMc D/C 09/02 16:00
Order#: 00001 Start: 09/04/07 08:43 Stop: 09/04/07 08:43 1 NS ORDER *FUROSEMIDE TAB 20 MG* X1 PO		09:00 CEK WTNS TMc			
Scheduled/Routine Medications					
Order#: 00002 Start: 08/29/07 08:49 Stop: 09/03/07 08:49 A NS ORDER *AMOXICILLIN {AUGMENTIN} TAB 250 MG* *TID PO	09:00 CEK 13:00 CEK 21:00 CEK	09:00 CEK 13:00 CEK 21:00 CEK	09:00 CEK 13:00 CEK 21:00 CEK	09:00 CEK 13:00 CEK 21:00 CEK	09:00 CEK 13:00 CEK 21:00 CEK
Order#: 00003 Start: 08/29/07 09:00 Stop: 09/08/07 09:00 A NS ORDER *LASIX {FUROSEMIDE} TB 40 MG* *QD PO	09:00 CEK	09:00 CEK	09:00 CEK	09:00 CEK	09:00 CEK
PRN Medications					
Order#: 00005 Start: 08/29/07 08:59 Stop: 09/12/07 08:59 A NS ORDER *MEPERIDINE {DEMEROL} SYR 50 MG* PRN Q6H IM GIVE WITH PHENERGAN PRN Q6H FOR PAIN **LINKED ORDER - Linked to next order**	09:00 CEK 15:00 CEK 21:00 CEK	03:00 CEK 09:00 CEK 15:00 CEK 21:00 CEK	03:00 CEK 09:00 CEK 15:00 CEK 21:00 CEK	03:00 CEK 09:00 CEK 15:00 CEK 21:00 CEK	03:00 CEK 09:00 CEK 15:00 CEK 21:00 CEK
Order#: 00006 Start: 08/29/07 09:00 Stop: 09/28/07 09:00 A NS ORDER *PROMETHAZINE AMP 25 MG* PRN Q6H IM GIVE WITH DEMEROL PRN Q6H FOR PAIN **LINKED ORDER**	09:00 CEK 15:00 CEK 21:00 CEK	03:00 CEK 09:00 CEK 15:00 CEK 21:00 CEK	03:00 CEK 09:00 CEK 15:00 CEK 21:00 CEK	03:00 CEK 09:00 CEK 15:00 CEK 21:00 CEK	03:00 CEK 09:00 CEK 15:00 CEK 21:00 CEK

PATIENT: BOLTZ CAROLYN NUMBER: 10000392 AGE: 62 SEX: F ROOM: 40102 PAGE: 1

- **Demographics Box:** Includes the patient's name, admitting physician, age, sex, date of birth, room number, medical record number, chief complaint, and any drug and food allergies documented through the TruBridge EHR system. In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

- **One-Time Orders:** This will display all X1 medications that were ordered, scheduled, administered or discontinued during the 5 day period covered by the report. Will also display order number, start and stop date, stop code and "Unverified" if the medication has not been verified, medication description, dosage, frequency, and instructions.

  The time of the administration and the initials of the person who administered the medication will appear under the appropriate column. If a medication was administered using the second witness option, the system will print the second employee's initials and time of medication administration in a bold font underneath the first employee's initials and time of medication administration.

  If the medication has a future start date or time and is administered before the start date and time, it will pull to the MAR with an “*” to the left of the administration area.

- **Scheduled / Routine Medications:** Displays all routine medications that were ordered, scheduled, administered or discontinued during the 5 day period covered by the report. Will also display the order number, start date, stop date if applicable, stop code if applicable, "Unverified" if the medication has not been verified, medication description, dosage, frequency, instructions, components and flow rate on piggybacks.

  The time of the administration and the initials of the person who administered the medication will appear under the appropriate column. If a medication was administered using the second witness option, the system will print the second employee's initials and time of medication administration in a bold font underneath the first employee's initials and time of medication administration.

  If the medication has a future start date or time and is administered before the start date and time, it will pull to the MAR with an “*” to the left of the administration area.

- **IV Orders:** Displays all continuous IVs that were ordered, scheduled, administered or discontinued during the 5 day period covered by the report. Will display the order number, start date, stop date if applicable, stop code if applicable, "Unverified" if the IV has not been verified, medication description, flow rate, frequency, and components.

  The time of the administration and the initials of the person who administered the medication will appear under the appropriate column. If a medication was administered using the second witness option, the system will print the second employee's initials and time of medication administration in a bold font underneath the first employee's initials and time of medication administration.

  If the medication has a future start date or time and is administered before the start date and time, it will pull to the MAR with an “*” to the left of the administration area.

  Alternating IV orders will be flagged with "***ALTERNATING IV SET 1***" or "Alt. IV Set 1***", with the number being the order number from the patient's pharmacy profile.

- **PRN Medications:** Displays all routine medications that were ordered, scheduled, administered or discontinued during the 5 day period covered by the report. Will display order number, start date, stop date if applicable, stop code if applicable, "Unverified" if the medication has not been verified, medication description, dosage, PRN frequency, instructions, components, and flow rate on piggybacks.

  The time of the administration and the initials of the person who administered the medication will appear under the appropriate column. If a medication was administered using the second witness option, the system will print the second employee's initials and time of medication administration in a bold font underneath the first employee's initials and time of medication administration.

  If the medication has a future start date or time and is administered before the start date and time, it will pull to the MAR with an “*” to the left of the administration area.

- **MISC Pharmacy Charges/Activities and Treatments (Optional):** Displays all miscellaneous charges, activities, and treatments that were ordered, scheduled, administered, or discontinued during the 5 day period covered by the report. Will display the order number, start date, stop date if applicable, stop code if applicable, "Unverified" if the medication has not been verified, description, dosage, frequency, and instructions.

  In order to print, Pharmacy department must answer field 17 “Treatment” in Pharmacy Order Entry. The time of administration and the initials of the person who administered the medication will appear under the appropriate column. If a medication was administered using the second witness option, the system will print the second employee's initials and time of medication administration in a bold font underneath the first employee's initials and time of medication administration.

NOTE: *Employees' initials must be set up in the Employee Master File of the Payroll application in order for them to print as an indication that a medication was administered. If no initials are set up, the system will print a "G" (Given) under the corresponding hour of the eight-hour block.*

Chapter 6 5 Day M.A.R

The MAR is a document that includes the patient's complete medication administration chart for the previous 5 days. Printing the 5 Day MAR is optional, unless otherwise specified by hospital policy, and can be printed at anytime during the patient's stay, but should be printed automatically at a specific hour, once a day.

The report is usually a permanent part of the patient's chart. For the first four days a temporary 5 Day MAR will print. A 5 Day MAR will print at the end of the 5th day of the patient's stay.

The nursing staff can print the report, but it is usually set up to automatically print at a specific hour. The report runs from midnight to midnight and should be printed before 8am. This will ensure that the correct information is captured on the report.

6.1 How to Print

The 5 Day M.A.R. - Final may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.

2. From the Virtual Chart select the appropriate tab.

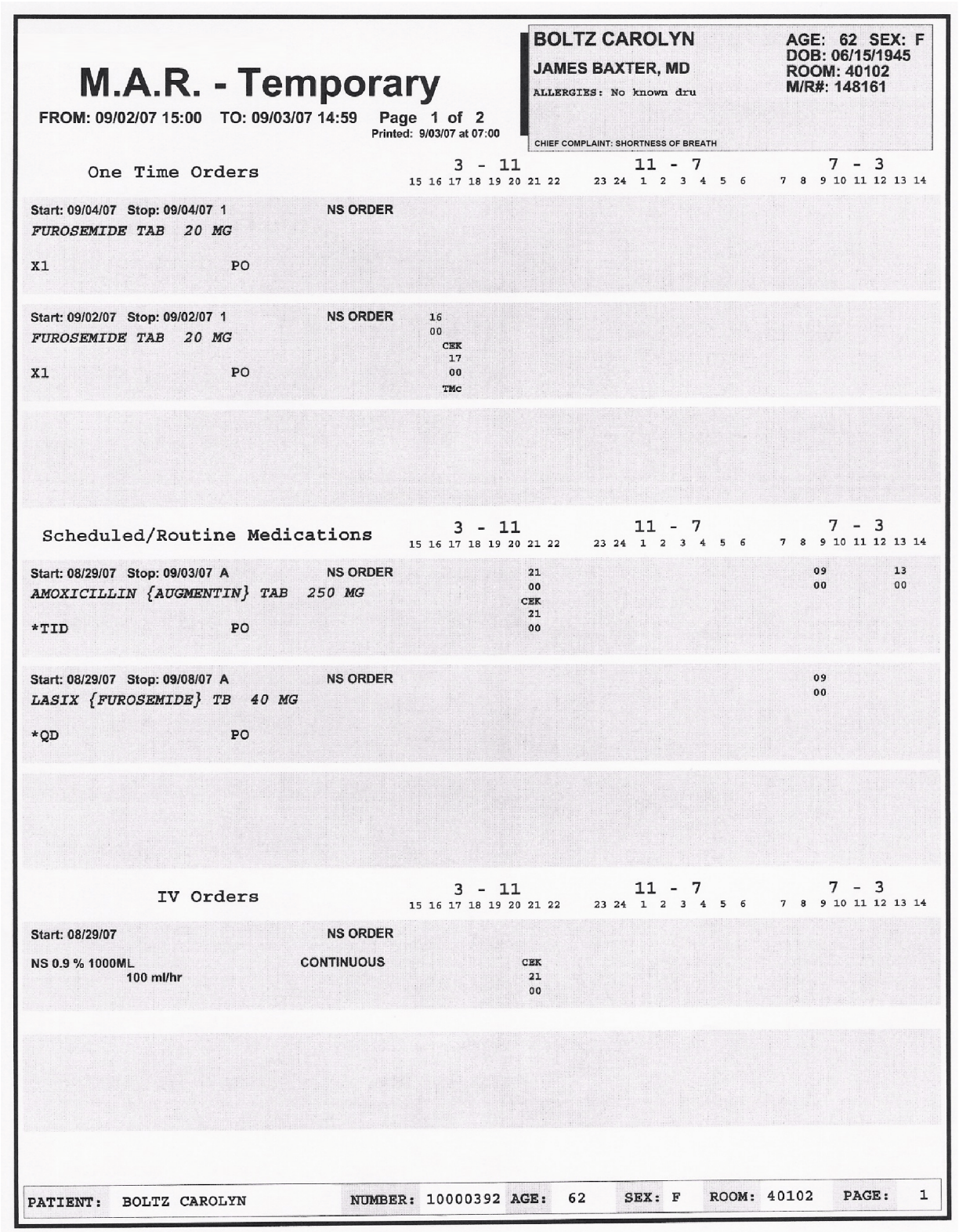
3. Select **5day MAR**.

6.2 Description and Usage

The MAR is a document that includes the patient's complete medication administration chart for the previous 5 days. The medications are grouped by categories (X1, Scheduled/Routine, IV orders, PRN, and MISC Pharmacy Charges/Activities and Treatments) and display in the order in that they were entered into the system. The previous day displays in column form, with the medication administration time(s), the initials of the nurse who administered the medication, and the actual time the medication was administered appearing below, if the medication was given. (The Medication Record that is printed from the Nursing Department, Hospital Base menu-X-A or the Nursing Department, Patient Functions Screen-Z, does not include the administration time(s) and the initials of the nurse who administered the medication.)

The Point of Care 5 DAY MAR takes the place of the Medication Record.

Temporary MAR - Page 1 of 2



M.A.R. - Temporary

FROM: 09/02/07 15:00 TO: 09/03/07 14:59 Page 1 of 2
Printed: 9/03/07 at 07:00

BOLTZ CAROLYN
JAMES BAXTER, MD
ALLERGIES: No known dru
CHIEF COMPLAINT: SHORTNESS OF BREATH

AGE: 62 SEX: F
DOB: 06/15/1945
ROOM: 40102
M/R#: 148161

One Time Orders

		3 - 11	11 - 7	7 - 3
		15 16 17 18 19 20 21 22	23 24 1 2 3 4 5 6	7 8 9 10 11 12 13 14
Start: 09/04/07 Stop: 09/04/07 1	NS ORDER			
FUROSEMIDE TAB 20 MG				
X1	PO			
Start: 09/02/07 Stop: 09/02/07 1	NS ORDER	16 00 CEK 17 00 TMc		
FUROSEMIDE TAB 20 MG				
X1	PO			

Scheduled/Routine Medications

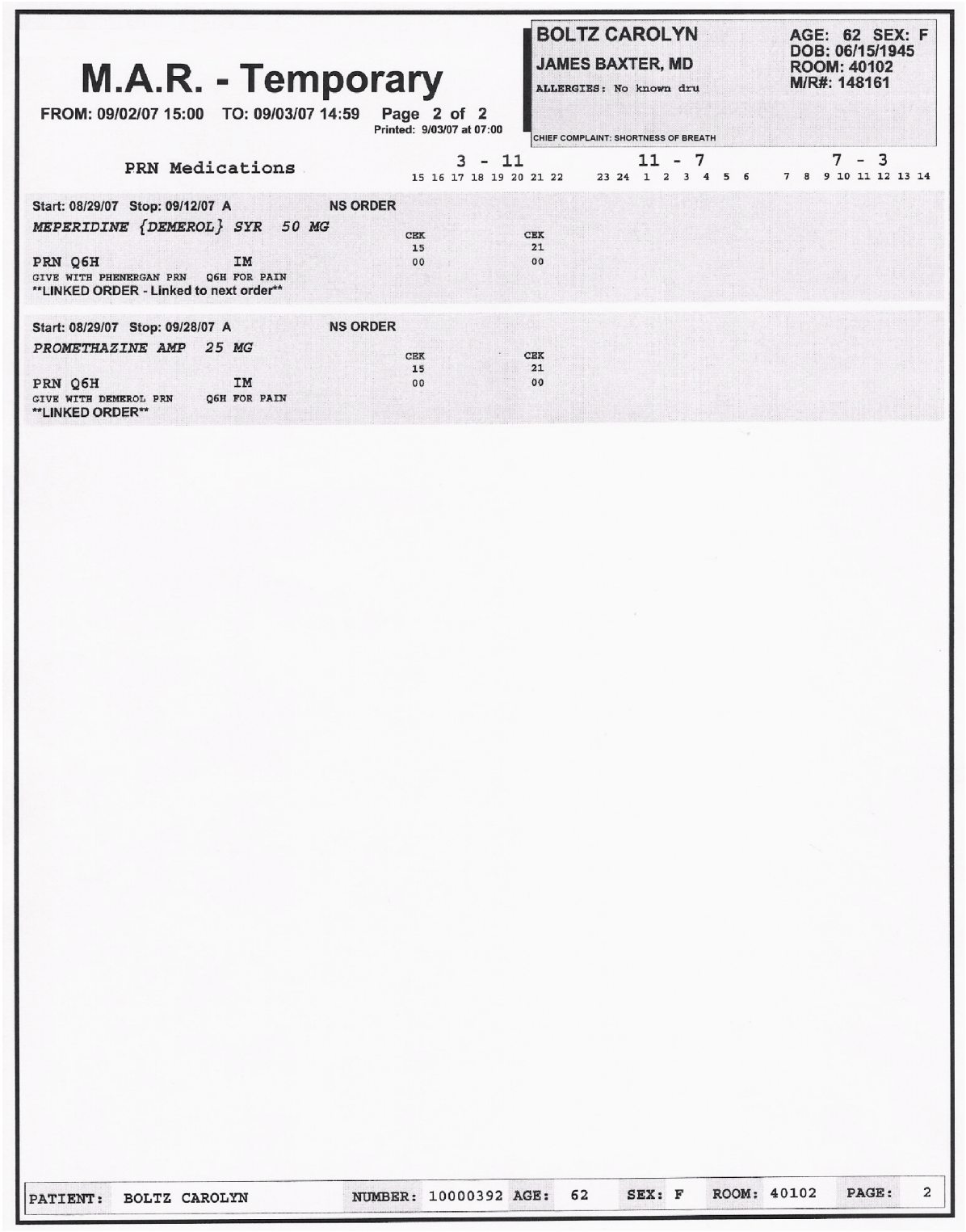
		3 - 11	11 - 7	7 - 3
		15 16 17 18 19 20 21 22	23 24 1 2 3 4 5 6	7 8 9 10 11 12 13 14
Start: 08/29/07 Stop: 09/03/07 A	NS ORDER	21 00 CEK 21 00		09 00 13 00
AMOXICILLIN {AUGMENTIN} TAB 250 MG				
*TID	PO			
Start: 08/29/07 Stop: 09/08/07 A	NS ORDER			09 00
LASIX {FUROSEMIDE} TB 40 MG				
*QD	PO			

IV Orders

		3 - 11	11 - 7	7 - 3
		15 16 17 18 19 20 21 22	23 24 1 2 3 4 5 6	7 8 9 10 11 12 13 14
Start: 08/29/07	NS ORDER			
NS 0.9 % 1000ML 100 ml/hr	CONTINUOUS	CEK 21 00		

PATIENT: BOLTZ CAROLYN NUMBER: 10000392 AGE: 62 SEX: F ROOM: 40102 PAGE: 1

Temporary MAR - Page 2 of 2



M.A.R. - Temporary

FROM: 09/02/07 15:00 TO: 09/03/07 14:59 Page 2 of 2
Printed: 9/03/07 at 07:00

BOLTZ CAROLYN
JAMES BAXTER, MD
ALLERGIES: No known dru
CHIEF COMPLAINT: SHORTNESS OF BREATH

AGE: 62 SEX: F
DOB: 06/15/1945
ROOM: 40102
M/R#: 148161

PRN Medications

		3 - 11							11 - 7							7 - 3						
		15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14

Start: 08/29/07 Stop: 09/12/07 A NS ORDER

MEPERIDINE {DEMEROL} SYR 50 MG

		CEK	CEK
		15	21
PRN Q6H	IM	00	00

GIVE WITH PHENERGAN PRN Q6H FOR PAIN
LINKED ORDER - Linked to next order

Start: 08/29/07 Stop: 09/28/07 A NS ORDER

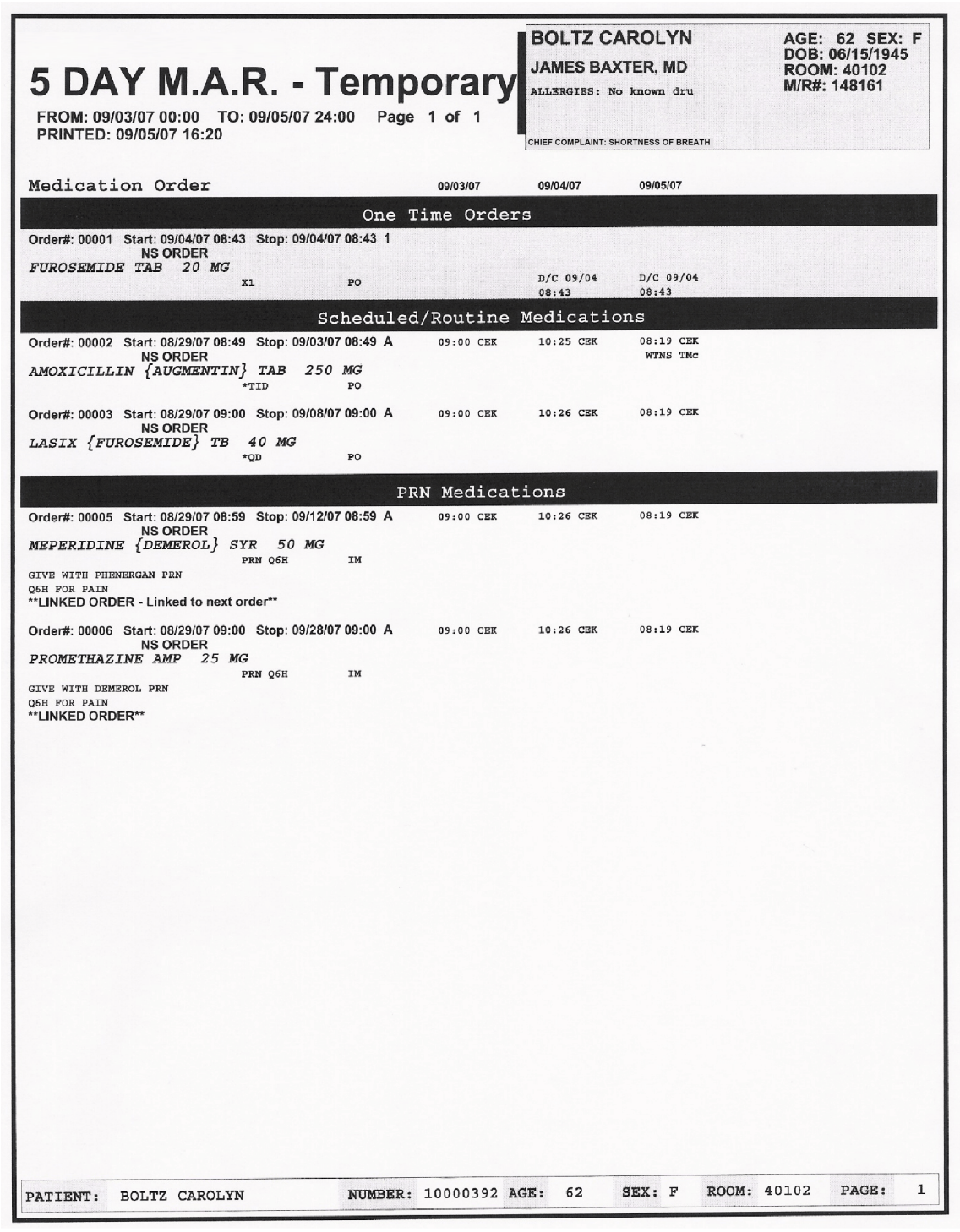
PROMETHAZINE AMP 25 MG

		CEK	CEK
		15	21
PRN Q6H	IM	00	00

GIVE WITH DEMEROL PRN Q6H FOR PAIN
LINKED ORDER

PATIENT: BOLTZ CAROLYN NUMBER: 10000392 AGE: 62 SEX: F ROOM: 40102 PAGE: 2

Temporary 5 Day MAR - Page 1 of 1



5 DAY M.A.R. - Temporary

FROM: 09/03/07 00:00 TO: 09/05/07 24:00 Page 1 of 1
PRINTED: 09/05/07 16:20

BOLTZ CAROLYN
JAMES BAXTER, MD
ALLERGIES: No known dru
CHIEF COMPLAINT: SHORTNESS OF BREATH

AGE: 62 SEX: F
DOB: 06/15/1945
ROOM: 40102
M/R#: 148161

Medication Order	09/03/07	09/04/07	09/05/07
One Time Orders			
Order#: 00001 Start: 09/04/07 08:43 Stop: 09/04/07 08:43 1 NS ORDER *FUROSEMIDE TAB 20 MG* X1 PO		D/C 09/04 08:43	D/C 09/04 08:43
Scheduled/Routine Medications			
Order#: 00002 Start: 08/29/07 08:49 Stop: 09/03/07 08:49 A NS ORDER *AMOXICILLIN {AUGMENTIN} TAB 250 MG* *TID PO	09:00 CEK	10:25 CEK	08:19 CEK WTNS TMc
Order#: 00003 Start: 08/29/07 09:00 Stop: 09/08/07 09:00 A NS ORDER *LASIX {FUROSEMIDE} TB 40 MG* *QD PO	09:00 CEK	10:26 CEK	08:19 CEK
PRN Medications			
Order#: 00005 Start: 08/29/07 08:59 Stop: 09/12/07 08:59 A NS ORDER *MEPERIDINE {DEMEROL} SYR 50 MG* PRN Q6H IM GIVE WITH PHENERGAN PRN Q6H FOR PAIN **LINKED ORDER - Linked to next order**	09:00 CEK	10:26 CEK	08:19 CEK
Order#: 00006 Start: 08/29/07 09:00 Stop: 09/28/07 09:00 A NS ORDER *PROMETHAZINE AMP 25 MG* PRN Q6H IM GIVE WITH DEMEROL PRN Q6H FOR PAIN **LINKED ORDER**	09:00 CEK	10:26 CEK	08:19 CEK

PATIENT: BOLTZ CAROLYN NUMBER: 10000392 AGE: 62 SEX: F ROOM: 40102 PAGE: 1

- **Demographics Box:** Displays patient's name, admitting physician, age, sex, date of birth, room number, medical record number, chief complaint, and any drug and food allergies documented through the TruBridge EHR system. In addition to the demographic box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

- **One-Time Orders:** Displays all X1 medications that were ordered, scheduled, administered or discontinued during the 5 day period covered by the report. Will display order number, start and stop date, stop code, "Unverified" if the medication has not been verified, medication description, dosage, frequency, and instructions.

  The time of the administration and the initials of the person who administered the medication will appear under the appropriate column. If a medication was administered using the second witness option, the system will print the second employee's initials and time of medication administration in a bold font underneath the first employee's initials and time of medication administration.

- **Scheduled / Routine Medications:** Displays all routine medications that were ordered, scheduled, administered or discontinued during the 5 day period covered by the report. Will display order number, start date, stop date if applicable, stop code if applicable, "Unverified" if the medication has not been verified, medication description, dosage, frequency, instructions, components and flow rate on piggybacks.

  The time of the administration and the initials of the person who administered the medication will appear under the appropriate column. If a medication was administered using the second witness option, the system will print the second employee's initials and time of medication administration in a bold font underneath the first employee's initials and time of medication administration.

- **IV Orders:** Displays all continuous IVs that were ordered, scheduled, administered or discontinued during the 5 day period covered by the report. Will display order number, start date, stop date if applicable, stop code if applicable, "Unverified" if the IV has not been verified, medication description, flow rate, frequency, and components.

  The time of the administration and the initials of the person who administered the medication will appear under the appropriate column. If a medication was administered using the second witness option, the system will print the second employee's initials and time of medication administration in a bold font underneath the first employee's initials and time of medication administration.

  Alternating IV orders will be flagged with "***ALTERNATING IV SET 1***" or "Alt. IV Set 1***", with the number being the order number from the patient's pharmacy profile.

- **PRN Medications:** Displays all routine medications that were ordered, scheduled, administered or discontinued during the 5 day period covered by the report. Will display order number, start date, stop date if applicable, stop code if applicable, "Unverified" if the medication has not been verified, medication description, dosage, PRN frequency, instructions, components, and flow rate on piggybacks

  The time of the administration and the initials of the person who administered the medication will appear under the appropriate column. If a medication was administered using the second witness option, the system will print the second employee's initials and time of medication administration in a bold font underneath the first employee's initials and time of medication administration.

- **MISC Pharmacy Charges/Activities and Treatments:** Displays all miscellaneous charges, activities, and treatments that were ordered, scheduled, administered, or discontinued during the 5 day period covered by the report. Will display order number, start date, stop date if applicable, stop code if applicable, "Unverified" if the medication has not been verified, description, dosage, frequency, and instructions.

  The time of administration and the initials of the person who administered the medication will appear under the appropriate column. If a medication was administered using the second witness option, the system will print the second employee's initials and time of medication administration in a bold font underneath the first employee's initials and time of medication administration.

NOTE: *Employees' initials must be set up in the Employee Master File of the Payroll application in order for them to print as an indication that a medication was administered. If no initials are set up, the system will print a "G" (Given) under the corresponding hour of the eight-hour block.*

Chapter 7 Activities

The Activities report is a document that includes completed activities for the patient. The nursing staff can print the report at anytime during the patient's stay. Printing the Activities report is optional, unless otherwise specified by hospital policy. The report is usually not a permanent part of the patient's chart.

7.1 How to Print

Activities may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart select the appropriate tab.
3. Select **Activities**.

   System prompts "Include stricken/amended data?"
4. This option will include any stricken or amended data in the report.

   System prompts, "Select Date Range."
5. Enter the dates that the reports is needed.

7.2 Description and Usage

The Activities report is a document that includes completed activities for the patient. The report can be printed to reflect all activities charted with in a specific shift, multiple shifts or from the beginning of stay.

Activities

Activities

ACTIVITIES Page 1 of 1

From beginning of stay TO: 02/10/00 08:00

WALSH KIERAN AGE: 49
SHAPIRO VICKI SEX: M
ALLERGIES: Bactrim Penicillin ROOM: TS002
M/R#: 012345

02/07/00

08:25 (ALD RN) **Safety**
Side rails up. Call bell in reach. Bed in low position. Arm band in place.

08:25 (ALD RN) **Activity**
Pt ambulated with assistance from P.T. Pt tolerated activity well.

08:25 (ALD RN) **IV Care**
IV restarted with a _20_ g catheter. Site:_Rt_Forearm_. IV Tubing changed.

08:32 (PDS CNA) **Nutrition**
75% of meal tolerated.

10:05 (CBA LPN) **Activity**
Pt up in chair.

12:23 (ALD RN) **Nutrition**
80% of meal tolerated.

13:06 (PDS CNA) **Safety**
Side rails up. Call bell in reach. Bed in low position.

13:06 (PDS CNA) **Elimination**
Pt assisted to BS commode. small amt of formed stool.

18:00 (ALD RN) **Nutrition**
100% of meal tolerated.

02/08/00

08:21 (PDS CNA) **Hygiene**
SELF BATH

08:21 (PDS CNA) **Safety**
Side rails up. Call bell in reach. Bed in low position.

08:21 (PDS CNA) **Nutrition**
75% of meal tolerated.

12:29 (ALD RN) **Activity**
Pt up in chair.

12:29 (ALD RN) **Nutrition**
100% of meal tolerated.

16:10 (CBA LPN) **Activity**
Pt up in chair. Pt tolerated activity well.

16:10 (CBA LPN) **Elimination**
Pt assisted to bathroom. large amt of brown, formed stool.

17:20 (ALD RN) **Nutrition**
75% of meal tolerated.

02/09/00

08:30 (PDS CNA) **Hygiene**
SELF BATH

08:30 (ALD RN) **Activity**
Pt up in chair.

08:30 (ALD RN) **Nutrition**
100% of meal tolerated.

08:30 (ALD RN) **Elimination**
Foley cath D/C'ed. Pt tolerated well.

11:00 (PDS CNA) **Elimination**
Pt assisted to bathroom. Voided clear urine.

PATIENT:	WALSH KIERAN	NUMBER:	100556	AGE:	49	SEX:	M	ROOM:	TS002	PAGE:	1

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Includes the patient's name, admitting physician, age, sex, room number, medical records number, and any drug allergies documented through the TruBridge EHR system. In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number, and page number will appear along the bottom edge of the page.

- **Activity Categories:** Each category will be highlighted with bold text and preceded by the following:
  - The time the entry was charted
  - The name and title of the individual that entered the information
  - Activity information is associated with, but not limited to the following areas:

• Hygiene	• Activity	• Safety
• IV Care	• Special Monitoring	• Special Equipment
• Pulmonary Treatments	• Wound Care	• Nutrition
• Elimination	• Isolation	• Sleep/Rest Pattern
• Patient Education	• Referrals	• Emotional Support

Chapter 8 Clinical Reports

8.1 Overview

This chapter will discuss reports available from the nursing stations Hospital Base Menu.

8.2 Description of Reports

NOTE: *Examples of the following reports can be found in the Point of Care Applications Manual.*

- **Dietary Orders -** The Dietary report will print all diets for all patients in your nursing station. It will sort in room number order. The purpose of printing this report is to make sure that all patients have the correct diet order before dietary prepares the tray.

- **Nursing Station Census (reg)** - This report is most often used to give shift report, however, it can be run depending on the needs of the nursing station. It sorts in room number order and provides much of the clinical information for each patient. The regular census provides room number, physician, advanced directive, weight, age, sex, service, condition, length of stay, diagnosis, drug allergies, and diet.

- **Nursing Station Census (mini)** - This report is most often printed before midnight to make sure that all patients are in the correct beds prior to the final census being run. It sorts in room number order and is an abbreviated version of the Regular Census report.

- **Bar Code Census -** The Bar Code Census report prints the room number and name of each patient associated with the nursing station. Bar code scanning capabilities must be available to use this report.

- **Specimen Collection List -** Nursing collected specimens may not always be collected at the time the procedure is ordered in the system. The Specimen Collection List was designed to show only uncollected nursing specimens and can be run at any time to easily track uncollected specimens.

- **Drug Information -** Drug monographs can be printed from the nursing station for use as a reference by the nursing staff or for patient education. Monographs are available only for medications distributed by your pharmacy. Each monograph includes information about uses, side effects, precautions, dosage, interactions, and storage.

- **Drug Interactions Report** - When using the TruBridge EHR Pharmacy application, a nursing station can view or print drug interactions for patient medications that are distributed by pharmacy. Up to six medications can be listed in the search.

- **Order Schedule -** All procedures for a specific ancillary department for a given time period can be printed. This particular report can be helpful in keeping track of daily ancillary orders such as lab orders when performing chart checks.

- **Floor Stock Charged Report -** The Floor Stock Charged report will print all floor stock charges for patients in a particular nursing station. Up to ten patient account numbers can be designated or all patient charges can be printed for a specific A/R date. It is recommended that the report can be printed after all charges are entered for the day, or shift, and be checked against charge labels for each patient.

- **Turn Around Time Report -** TAT can be run from any Ancillary or Nursing department. This report searches through the order records to find user-selected information. Any two Order Entry Maintenance records with a date/time can be selected for comparison.

- **Ancil Re-Orders Due -** Nursing departments can print a report and/or labels for orders that are scheduled to discontinue within 24 hours. If labels are printed, the label can be placed on the patient's chart to remind the physician that the order is scheduled to stop if it is not reordered. The report is useful for change of shift reports or for physician review.

- **Physician's Rounds Sheets -** Nursing departments can print this report for physician's to utilize while making rounds. The report includes the patient's name, room number, account number, financial class, age, sex, marital status, number of days in hospital, diagnosis, admitting physician, second or consulting physician, family physician, patient's phone number, and medical records number.

- **Comparative Results -** The cumulative vertical report is an update of all test results for a patient account. The report is a comparative summary presentation of all data with test names along the vertical axis and results listed chronologically along a horizontal axis. Collection dates and times are printed on the horizontal axis. Up to seven events will print per row with subsequent results wrapping below the most current results. Since this report is a complete record of all patient results, each report should replace the report previously charted. Preliminary reports with results that do not yet appear on the cumulative report should remain on the chart until they print on the cumulative.

- **Multi Acct Cumvert –** This report prints the same as Comparative Results but will include all patient accounts (inpatient or outpatient) within a predefined number of months.

Chapter 9 Critical Care Flow Sheet

The Critical Care Flow Sheet is a document that includes specific patient information charted within an eight-hour (or less) time frame. It can be printed at anytime during the patient's stay, but it is primarily printed at the end of shift. The nursing staff can print the report, but the nurse assigned to the patient primarily prints it. Printing the Critical Care Flow Sheet is optional, unless otherwise specified by hospital policy. The report is usually not a permanent part of the patient's chart, but it placed in the patient's chart for physician rounds.

9.1 How to Print

The Critical Care Flow Sheet may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart select the appropriate tab.
3. Select Critical Care Flowsheet.
4. Select a patient by choosing "This Department", "My Patients", or "Current Patients."
5. Click patient name and then "Add Selected" to add patient to Patient Selection List
6. Select **Process**.

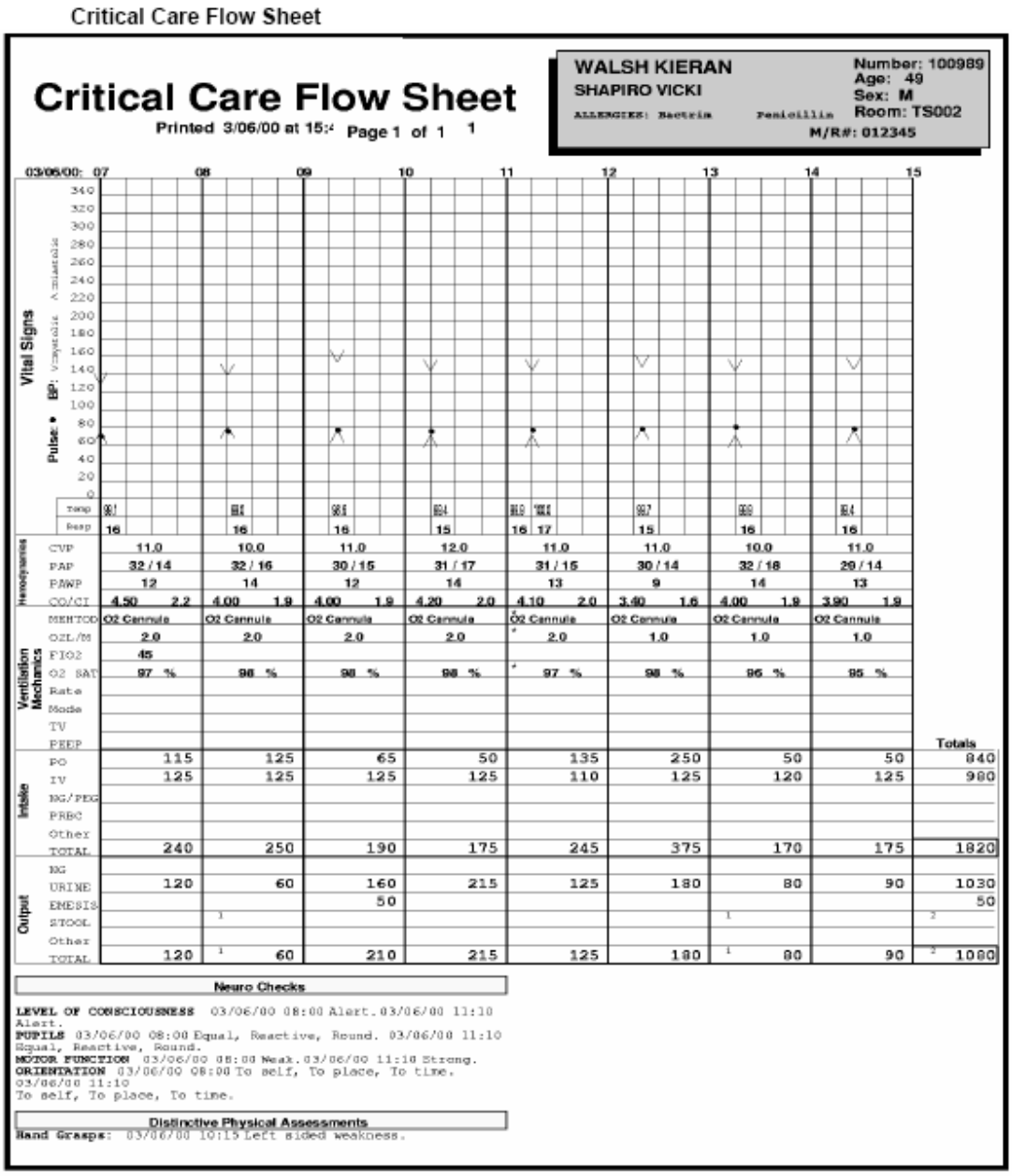
   System prompts "Select Ending Time for the Critical Care Flow Sheet."
7. Choose the Current Ending Date and Time that the report is needed.
8. Select **Print**.

   System prompts "Enter Number of Copies to Print"
9. Enter the number of copies to print.
10. Select **OK**.

9.2 Description and Usage

The Critical Care Flow Sheet is a document that includes specific patient information charted within an eight-hour (or less) time frame. The report provides details of the patient's condition and plan of care and can also be used to track trends in the patient's progress. It is primarily used in the ICU.

Critical Care Flow Sheet


Critical Care Flow Sheet

Critical Care Flow Sheet

Printed 3/06/00 at 15:4 Page 1 of 1

WALSH KIERAN
SHAPIRO VICKI
ALLERGIES: Bactrim Penicillin
Number: 100989
Age: 49
Sex: M
Room: TS002
M/R#: 012345

03/06/00: 07 08 09 10 11 12 13 14 15

Vital Signs — Pulse: • BP: Systolic Diastolic

Temp	98	98	98	98	98 98	98	99	98	
Resp	16	16	16	15	16 17	15	16	16	
Hemodynamics — CVP	11.0	10.0	11.0	12.0	11.0	11.0	10.0	11.0	
PAP	32 / 14	32 / 16	30 / 15	31 / 17	31 / 15	30 / 14	32 / 18	29 / 14	
PAWP	12	14	12	14	13	9	14	13	
CO/CI	4.50 2.2	4.00 1.9	4.00 1.9	4.20 2.0	4.10 2.0	3.40 1.6	4.00 1.9	3.90 1.9	
Ventilation Mechanics — METHOD	O2 Cannula	O2 Cannula	O2 Cannula	O2 Cannula	O2 Cannula	O2 Cannula	O2 Cannula	O2 Cannula	
OZL/M	2.0	2.0	2.0	2.0	2.0	1.0	1.0	1.0	
FIO2	45								
O2 SAT	97 %	98 %	98 %	98 %	97 %	98 %	96 %	95 %	
Rate									
Mode									
TV									
PEEP									Totals
Intake — PO	115	125	65	50	135	250	50	50	840
IV	125	125	125	125	110	125	120	125	980
NG/PEG									
PRBC									
Other									
TOTAL	240	250	190	175	245	375	170	175	1820
Output — NG									
URINE	120	60	160	215	125	180	80	90	1030
EMESIS			50						50
STOOL		1					1		2
Other									
TOTAL	120	1 60	210	215	125	180	1 80	90	2 1080

Neuro Checks

LEVEL OF CONSCIOUSNESS 03/06/00 08:00 Alert. 03/06/00 11:10 Alert.
PUPILS 03/06/00 08:00 Equal, Reactive, Round. 03/06/00 11:10 Equal, Reactive, Round.
MOTOR FUNCTION 03/06/00 08:00 Weak. 03/06/00 11:10 Strong.
ORIENTATION 03/06/00 08:00 To self, To place, To time. 03/06/00 11:10 To self, To place, To time.

Distinctive Physical Assessments

Hand Grasps: 03/06/00 10:15 Left sided weakness.

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Includes the patient's name, account number, admitting physician, age, sex, room number, medical records number, and any drug allergies documented through the TruBridge EHR system.
- **Vital Signs:** The pulse and blood pressure will display graphically in 15 minute intervals. The temperature and respirations will display numerically in 15 minute intervals. Will also display O2, O2 L/Min, FiO2, and O2 Sat.

- **Hemodynamics:** The CVP, PAP, PAWP, and CO/CI values will display in one hour intervals.

- **Ventilation Mechanics (Optional):** Nursing Administration determines which seven out of twelve options will display. The values will display in one hour intervals.

- **Intake (Optional):** Nursing Administration determines which four out of twelve options will display. The values will display in one hour intervals. The "OTHER" box combines all intake values not specified on the flow sheet, which can be seen in detail in the Patient Progress Notes.

- **Output (Optional):** Nursing Administration determines which four out of eighteen options will display. The values will display in one hour intervals. The "OTHER" box combines all output values not specified on the flow sheet, which can be seen in detail in the Patient Progress Notes. Entries charted by frequency, display in the top left corner of the boxes where volume entries also display.

NOTE: *An asterisk (*) adjacent to any value on this flow sheet denotes multiple values have been charted. The first recorded value displays, with subsequent values listed in the Patient Progress Notes.*

- **Medications:** Displays medications administered during the selected time frame, Hemodynamic medications, date and time of last administration, medication description, location of administration, or reason if it is a PRN, and dosage.

- **Neuro checks:** Displays neuro checks charted through the VS application since last locked shift. Will also display the date and time information was entered, as well as the name and title of person who charted the entry.

- **Distinctive Nursing Assessments:** Displays assessments charted in the eight hour period covered, that are flagged as distinctive and should be noted by the nursing staff, as well as the date and time of entry. In order for this information to be reflected, it must be set up by Nursing Administration.

- **Distinctive Physical Assessments:** Displays assessments charted in the eight hour period covered, that are flagged as distinctive and should be noted by the medical staff, as well as the date and time of entry. In order for this information to be reflected, it must be set up by Nursing Administration.

Chapter 10 Diabetic Flow Sheet

Q. HOW OFTEN SHOULD THE REPORT BE PRINTED?
A. The Diabetic Flow Sheet can be printed at any time during the patient's stay, but should be printed at the end of each shift or automatically at a specific hour, once a day.

Q. WHO CAN PRINT THE REPORT?
A. The nursing staff can print the report, but the nurse assigned to the patient primarily prints it or it is set up to print automatically at a specific hour.

Q. WHO SHOULD GET COPIES OF THIS REPORT?
A. The Diabetic Flow Sheet is placed in the patient's chart and replaced each time a current report is printed.

Q. IS PRINTING MANDATORY OR OPTIONAL?
A. Printing the Diabetic Flow Sheet is mandatory, unless otherwise specified by hospital policy. The report is usually a permanent part of the patient's record.

Q. WHAT IS THE DESCRIPTION AND USAGE?
A. The Diabetic Flow Sheet is a cumulative document that includes the patient's diabetic chart, PRN and routine insulin, and oral agent administrations.

- There are three versions of the Diabetic Flow Sheet:
  - **Version 1:** Cumulative report of all insulin and blood glucose levels.
  - **Routine:** 7-day graphic representation of blood glucose levels.
  - **ICU:** 24-hour graphic representation of blood glucose levels.

- Version 1 Diabetic Flow Sheet contains the following information:
  - **Demographics Box** (located in the upper-right corner)
    - Patient's name
    - Admitting physician
    - Age, sex, & room number
    - Medical Records number
    - Any drug allergies documented through the TruBridge EHR system
    - In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number, and page number will appear along the bottom edge of the page.
  - **Diet:** The patient's current diet will display in the upper-right corner of the report, just below the demographics box.
  - **Sliding Scale:** The scale is highlighted in a gray box. It provides the following information:
    - Date and time the scale was entered, as well as the name and title of the person who entered it.
    - Low and high blood sugar values, as well as the appropriate insulin dosage.
    - Comments, if selected to print. This feature is controlled by a switch in the Point of Care Control Record and is optional.
    - If no sliding scale has been ordered, or if one has been discontinued, it will be indicated by the following values and dosage: 0 - 999 0

- **Below the Scale**
  - Date and time of each entry charted.
  - Name and title of the person who charted each entry. If a medication was administered using the second witness option, the system will print the second employee's initials and time of medication administration in a bold font underneath the first employee's initials and time of medication administration.
  - Blood glucose level and dose (if administered).
  - Type of insulin or oral agent administered.
  - The site where the medication was given.
  - Any additional interventions that were performed.

Q. WHAT ARE THE SETUP OPTIONS FOR PRINTING?
A. The Diabetic Flow Sheet can be set up to print:

- As part of end-of-shift reports
- As part of discharge reports
- Automatically at a specific hour to a specific printer
- At a set interval, spooled to the PC Backup

Setup is completed in the Department Control Table for Point of Care, which can be accessed from the **Hospital Base Menu** > **Nursing Administration Department** > **Master Selection** > **Business Office Tables** > **Business Office Table Maintenance** > **POC Departments**. The code for this report is **DFS**.

The Routine Diabetic Flow Sheet contains the following information:

- **Demographics Box** (located in the upper-right corner)
  - Patient's name
  - Admitting physician
  - Account number, age, sex, & room number
  - Medical Records number
  - Any drug allergies documented through the TruBridge EHR system
- **Diet**
  - The patient's current diet will display in the top right corner of the report, just below the demographics box.
- **Graphic Display**
  - 7 Day graphic representation of all blood glucose levels.
  - Report prints a **Temporary** (current 7 day period) and a **Final** (completed 7 day period) graph.
  - All blood sugar levels plot on the graph, however only the most recent level/time in each 6-hour increment prints on the report.
  - Asterisks indicate more than one level charted within a 6-hour increment.
  - Interventions print vertically within the time period for which they were performed.

- Lab results plot separately and are indicated in bold.
- Diet percent consumed also graphs. Information pulls from recordings performed in Medact.
- Individual totals for NPH, Regular, IV, and Miscellaneous insulin, as well as oral agents given, print in 6-hour increments.

- **Sliding Scale**
  - Sliding scales print on a separate page.
  - The date, time, name, and credentials of the person who entered the scale will print.
  - It will indicate if the sliding scale is IV or subcutaneous.
  - Gray indicates an inactive sliding scale.
  - White indicates an active sliding scale.
  - Comments, if selected to print. This feature is controlled by a switch in the Point of Care Control Record and is optional.

- **Legend**
  - Located in the lower-left corner of the Diabetic Flow Sheet.
  - "*" indicates more than one result during this time period.
  - "^" indicates a blood glucose > 1000.
  - "o" or plain text indicates Point of Care entry or Bold indicates Lab result.

NOTE: *In order for lab glucose results to pull to the Diabetic Flow Sheet, the POC control record must be set up to include the items from lab. The item descriptions listed in the POC control record must be set up in the Reference Range Tables. Consult lab manager for assistance.*

The ICU Diabetic Flow Sheet contains the following information:

- **Demographics Box** (located in the upper-right corner)
  - Patient's name
  - Admitting physician
  - Account number, age, sex, & room number
  - Medical Records number
  - Any drug allergies documented through the TruBridge EHR system

- **Diet**
  - The patient's current diet will display in the top-right corner of the report, just below the demographics box.

- **Graphic Display**
  - 24-Hour graphic representation of all blood glucose levels.
  - Report prints a **Temporary** (current 24-Hour period) and a **Final** (completed 24-Hour period) graph.
  - All blood sugar levels plot on the graph, however only the most recent level/time in each 1-hour increment prints on the report.
  - Asterisks indicate more than one level charted within 1 hour increment.
  - Interventions print vertically within the time period for which they were performed.
  - Lab results plot separately and are indicated in bold.
  - Diet percent consumed also graphs. Information pulls from recordings performed in Medact.
  - Individual totals for NPH, Regular, IV and Miscellaneous insulin, as well as oral agents given, print in 1-hour increments.

- **Sliding Scale**
  - Sliding scales print on a separate page.
  - The date, time, name, and credentials of the person who entered the scale will print.
  - It will indicate if the sliding scale is IV or subcutaneous.
  - Gray indicates an inactive sliding scale.
  - White indicates an active sliding scale.
  - Comments, if selected to print. This feature is controlled by a switch in the Point of Care Control Record and is optional.

- **Legend**
  - Located in the lower-left corner of the Diabetic Flow Sheet.
  - "*" indicates more than one result during this time period.
  - "^" indicates a blood glucose > 1000.
  - "o" or plain text indicates Point of Care entry or Bold indicates Lab result.

NOTE: *In order for lab glucose results to pull to the Diabetic Flow Sheet, the POC control record must be set up to include the items from lab. The item descriptions listed in the POC control record must be set up in the Reference Range Tables. Consult lab manager for assistance.*

Diabetic Flow Sheet

DIABETIC FLOW SHEET

Page 1 of 1

ANDERS NEIL
BARNES PATRICK
ALLERGIES: No Known Dru

AGE: 29
SEX: M
ROOM: 501
M/R#: 897946562

DIET: REGULAR

SLIDING SCALE DATA...	LOW-HIGH DOSE	Comments
05/18/04 07:00 (JJD, RN) Subcutaneous	0- 60 0.00 61-150 0.00 151-200 2.00 201-250 4.00 251-300 6.00 301-350 8.00 351-400 10.00 401-999 0.00	IF BG <55 GIVE 1/2 AMP D50 IF BG 55-60 GIVE OJ W/SUGAR

Recorded by...	BLOOD GLUCOSE/DOSE	INSULIN/HYPOGLYCEMIC GIVEN	SITE/OMIT REASON	IK	OTHER INTERVENTION
05/18/04 07:00 (JJD, RN)	175 2 UN	HUMULIN 50/50	RIGHT ARM	N	
10:42 (JJD, RN)	130			N	
16:00 (JJD, RN)	58			N	ORANGE JUICE W/SUGAR GIVEN
21:10 (JJD, RN)	204 4 UN	HUMULIN 50/50	RIGHT THIGH	N	
05/19/04 07:00 (JJD, RN)	79			N	LAB BLOOD GLUCOSE DRAWN
11:26 (JJD, RN)	168 2 UN	HUMULIN 50/50	LEFT ARM	N	

SLIDING SCALE DATA...	LOW-HIGH DOSE	Comments
05/19/04 11:27 (JJD, RN) Subcutaneous	0- 60 0.00 61-120 0.00 121-150 2.00 151-200 4.00 201-250 6.00 251-300 8.00 301-350 10.00 351-400 12.00 401-999 0.00	IF BG <55 GIVE 1/2 AMP D50 IF BG 55-60 GIVE OJ W/SUGAR

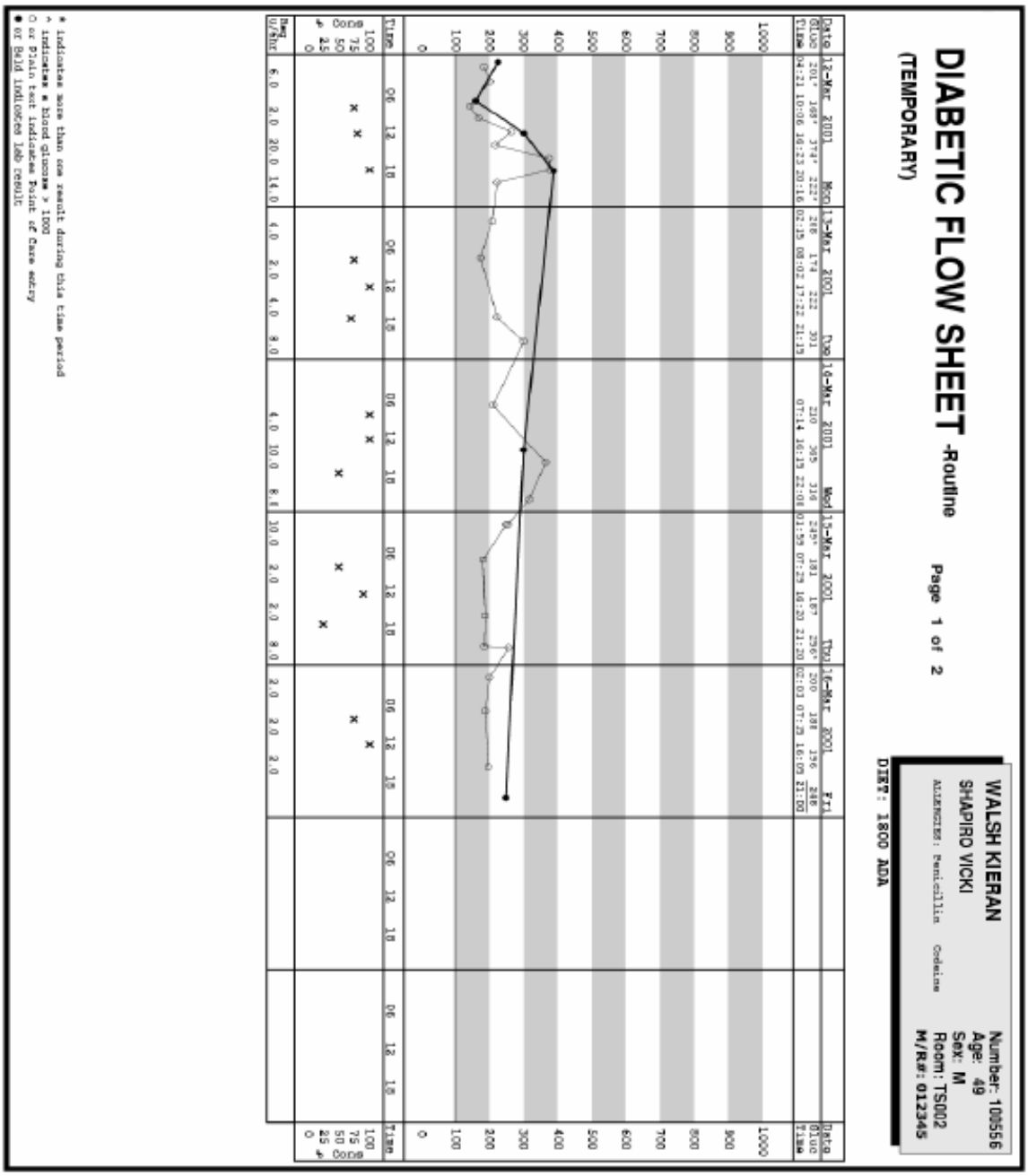
Recorded by...	BLOOD GLUCOSE/DOSE	INSULIN/HYPOGLYCEMIC GIVEN	SITE/OMIT REASON	IK	OTHER INTERVENTION
05/19/04 16:00 (JJD, RN)	204 6 UN	HUMULIN 50/50	LEFT THIGH	N	
21:10 (JJD, RN)	115			N	
05/20/04 07:00 (JJD, RN)	53			N	1/2 AMP D50
11:05 (JJD, RN)	143 2 UN	HUMULIN 50/50	RIGHT ARM	N	
16:05 (JJD, RN)	200 4 UN	HUMULIN 50/50	LEFT ARM	N	
21:00 (JJD, RN)	115			N	
05/21/04 07:05 (JJD, RN)	94			N	
10:58 (JJD, RN)	115			N	

ADDRESSED VIA MAR...

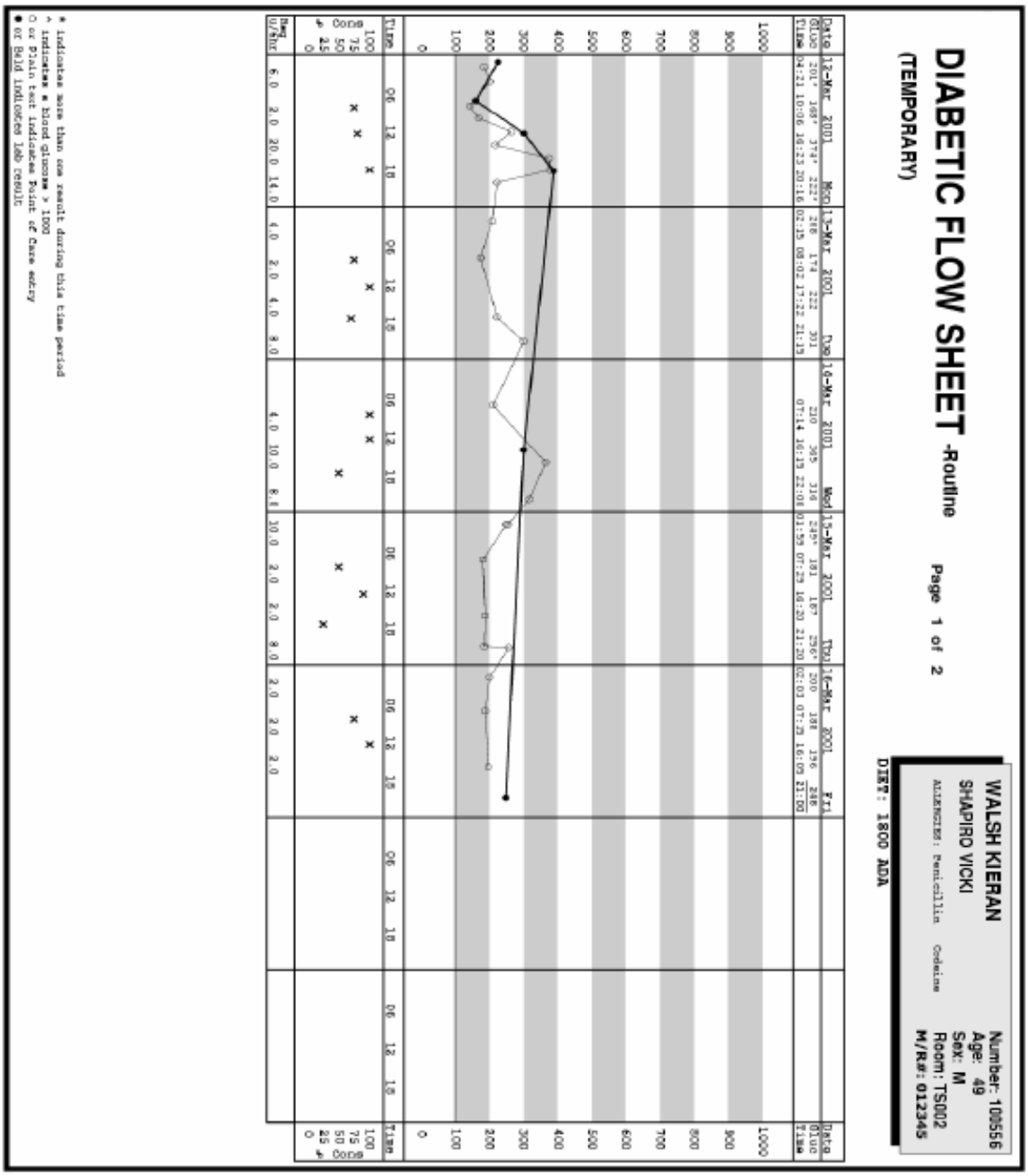
Recorded by...	BLOOD GLUCOSE/DOSE	INSULIN/HYPOGLYCEMIC GIVEN	SITE/OMIT REASON	IK	OTHER INTERVENTION
05/18/04 10:00 (JJD, RN)	No BG 10 UN	HUMULIN 70/30	RIGHT HIP	N	

PATIENT:	ANDERS NEIL	NUMBER:	401247	AGE:	29	SEX:	M	ROOM:	501	PAGE:	1

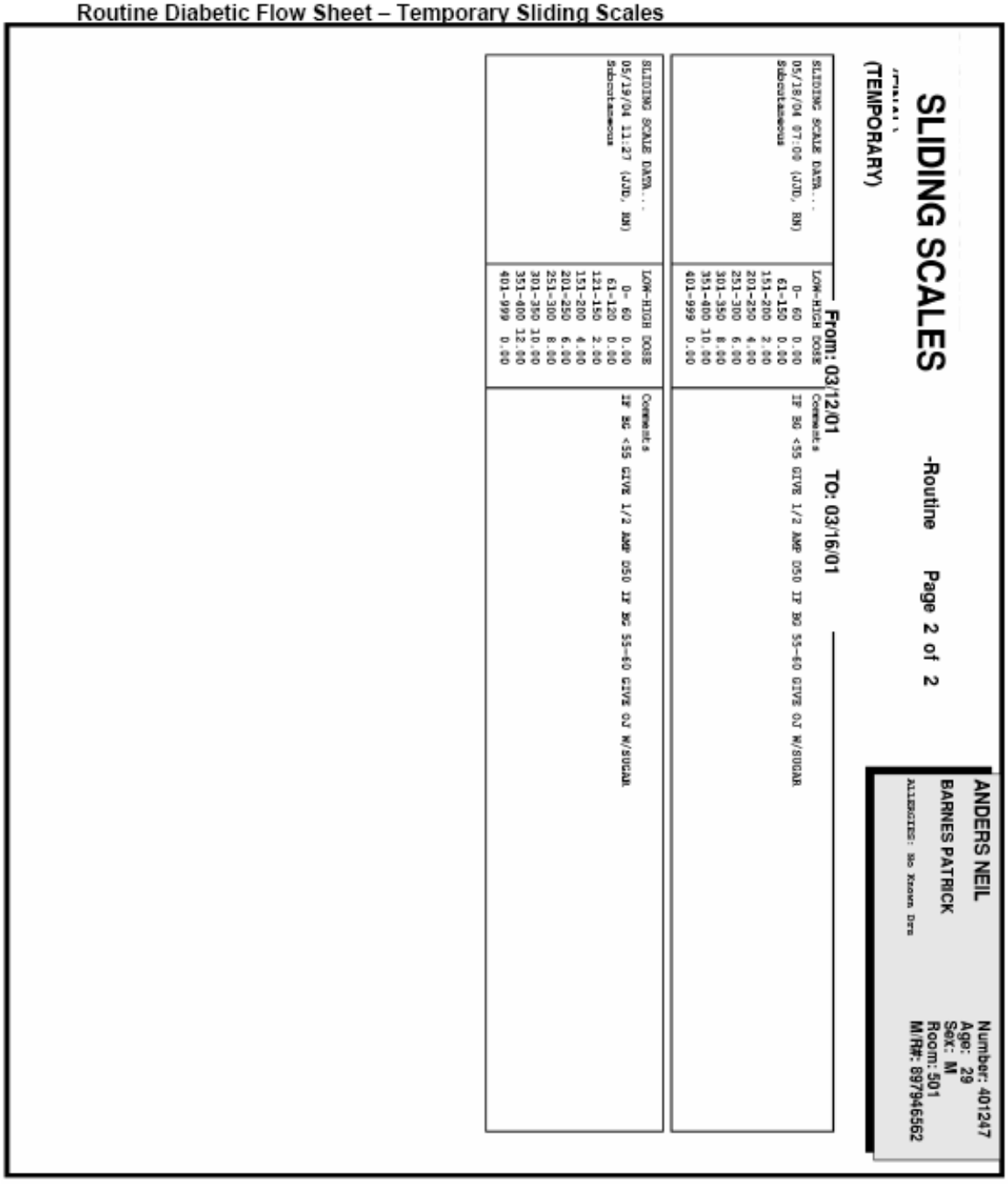
Routine Diabetic Flow Sheet – Temporary



Routine Diabetic Flow Sheet – Temporary



Routine Diabetic Flow Sheet – Temporary Sliding Scales



SLIDING SCALES -Routine Page 2 of 2

(TEMPORARY)

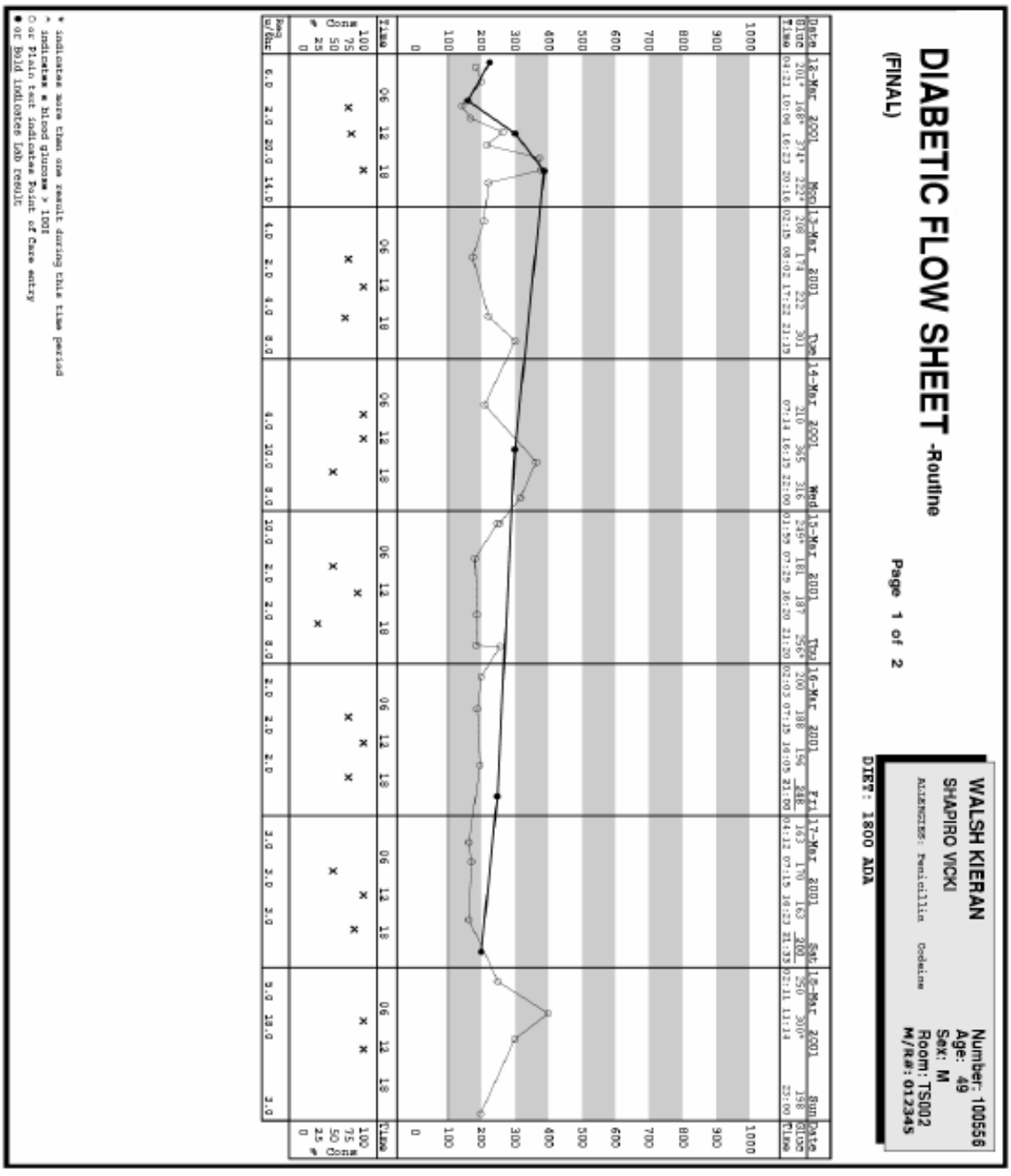
ANDERS NEIL Number: 401247
BARNES PATRICK Age: 29
Sex: M
Room: 501
M/R#: 897946562
ALLERGIES: No Known Drs

From: 03/12/01 TO: 03/16/01

SLIDING SCALE DATA...	LOW-HIGH DOSE	Comments
05/18/04 07:00 (JJD, RN) Subcutaneous	0- 60 0.00	IF BG <55 GIVE 1/2 AMP D50 IF BG 55-60 GIVE OJ W/SUGAR
	61-150 0.00	
	151-200 2.00	
	201-250 4.00	
	251-300 6.00	
	301-350 8.00	
	351-400 10.00	
	401-999 0.00	

SLIDING SCALE DATA...	LOW-HIGH DOSE	Comments
05/19/04 11:27 (JJD, RN) Subcutaneous	0- 60 0.00	IF BG <55 GIVE 1/2 AMP D50 IF BG 55-60 GIVE OJ W/SUGAR
	61-120 0.00	
	121-150 2.00	
	151-200 4.00	
	201-250 6.00	
	251-300 8.00	
	301-350 10.00	
	351-400 12.00	
	401-999 0.00	

Routine Diabetic Flow Sheet – Final



Routine Diabetic Flow Sheet – Final Sliding Scales

SLIDING SCALES

-Routine

Page 2 of 2

(FINAL)

WALSH KIERAN
SHAPIRO VICKI
ALLERGIES: Penicillin Codeine

Number: 100556
Age: 49
Sex: M
Room: TS002
M/R#: 012345

From: 03/19/01 TO: 03/19/01

SLIDING SCALE DATA...
03/14/01 06:12 (DOE, EN)
Subcutaneous

LOW-HIGH	DOSE
0- 60	0.00
61-150	0.00
151-200	2.00
201-250	4.00
251-300	6.00
301-350	8.00
351-400	10.00
401-999	0.00

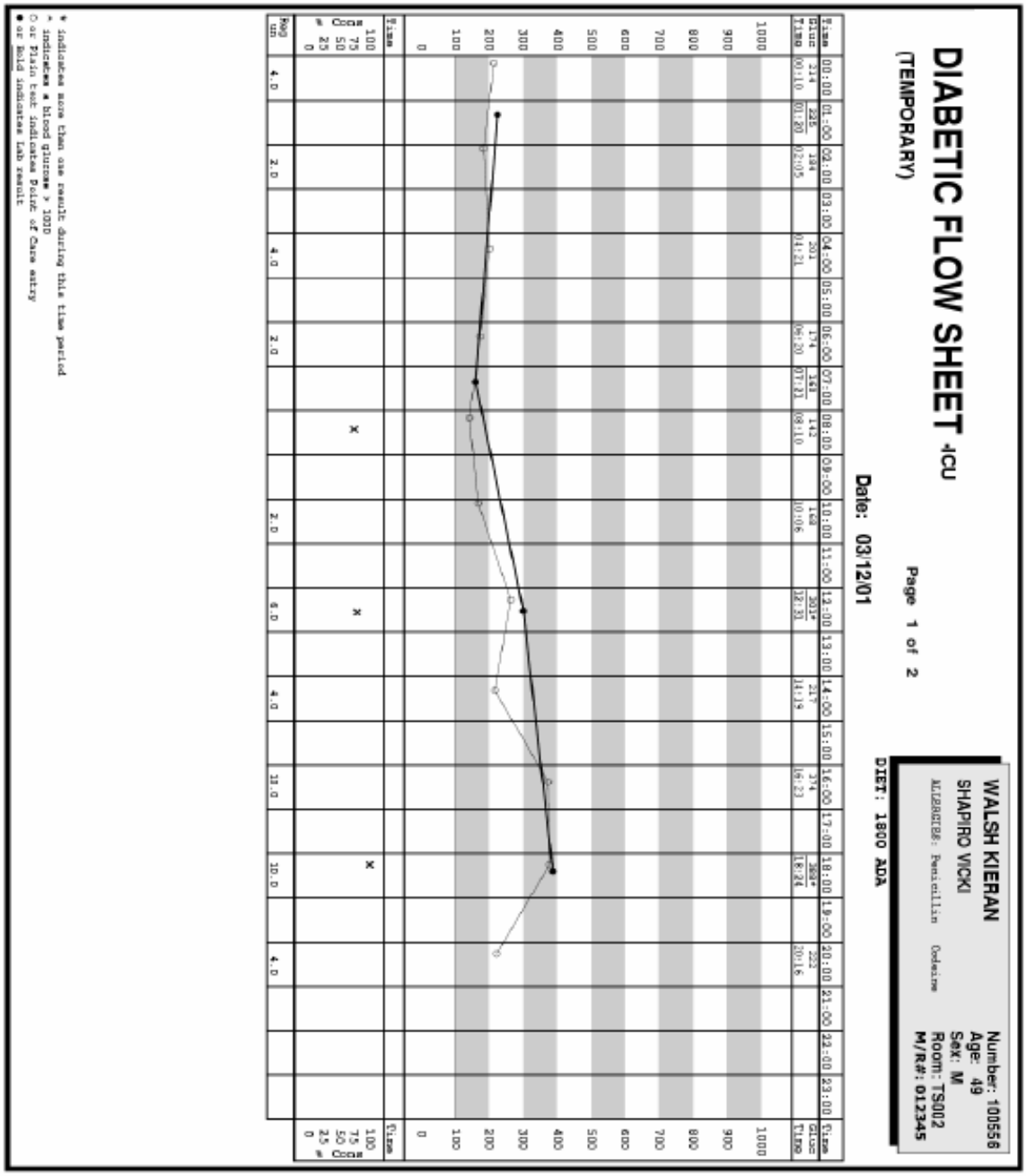
Comments
IF BG <55 GIVE 1/2 AMP D50 IF BG 55-60 GIVE OJ W/SUGAR

SLIDING SCALE DATA...
03/14/01 06:12 (DOE, EN)
Subcutaneous

LOW-HIGH	DOSE
0- 60	0.00
61-120	0.00
121-150	2.00
151-200	4.00
201-250	6.00
251-300	8.00
301-350	10.00
351-400	12.00
401-999	0.00

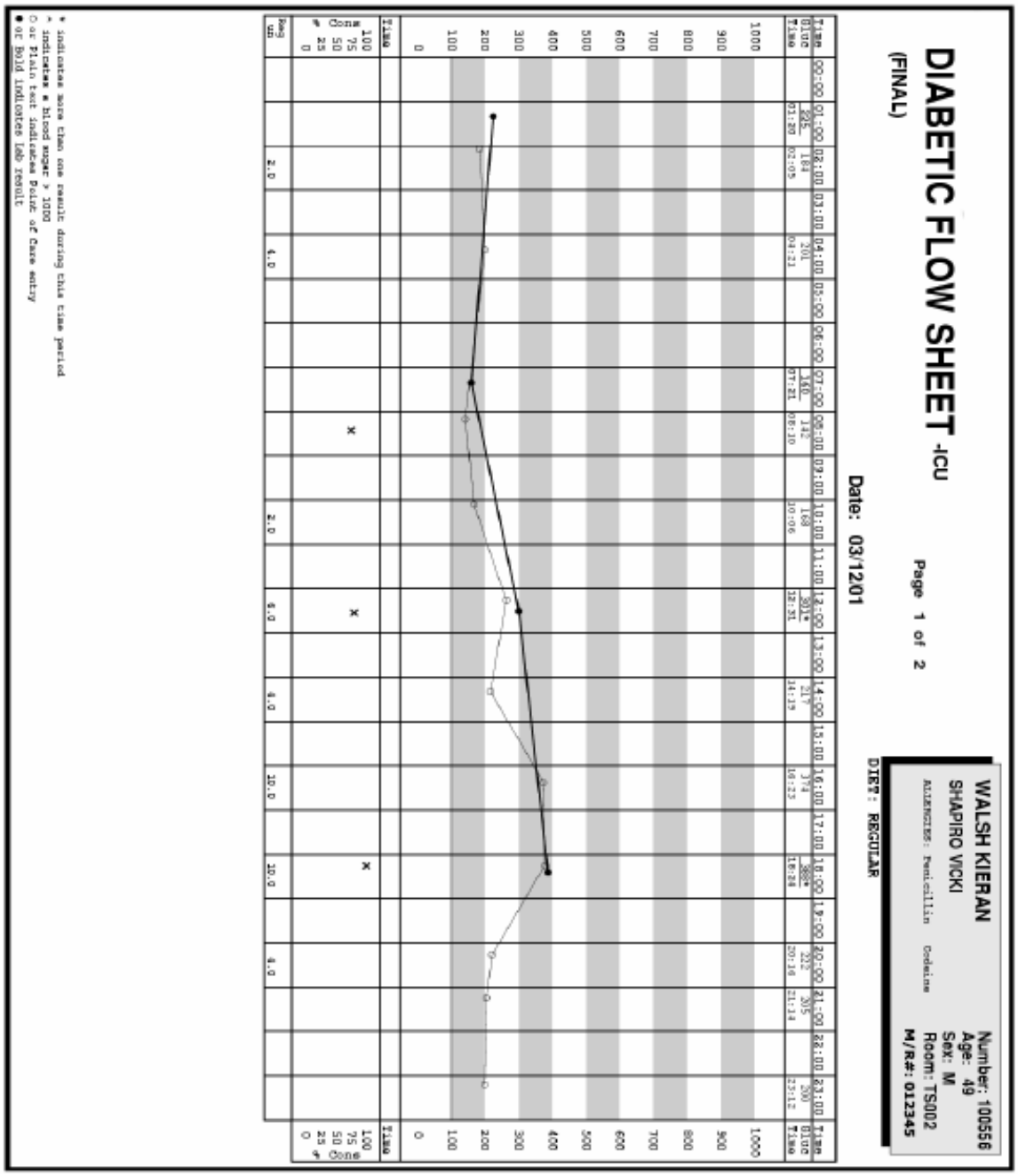
Comments
IF BG <55 GIVE 1/2 AMP D50 IF BG 55-60 GIVE OJ W/SUGAR

ICU Diabetic Flow Sheet - Temporary

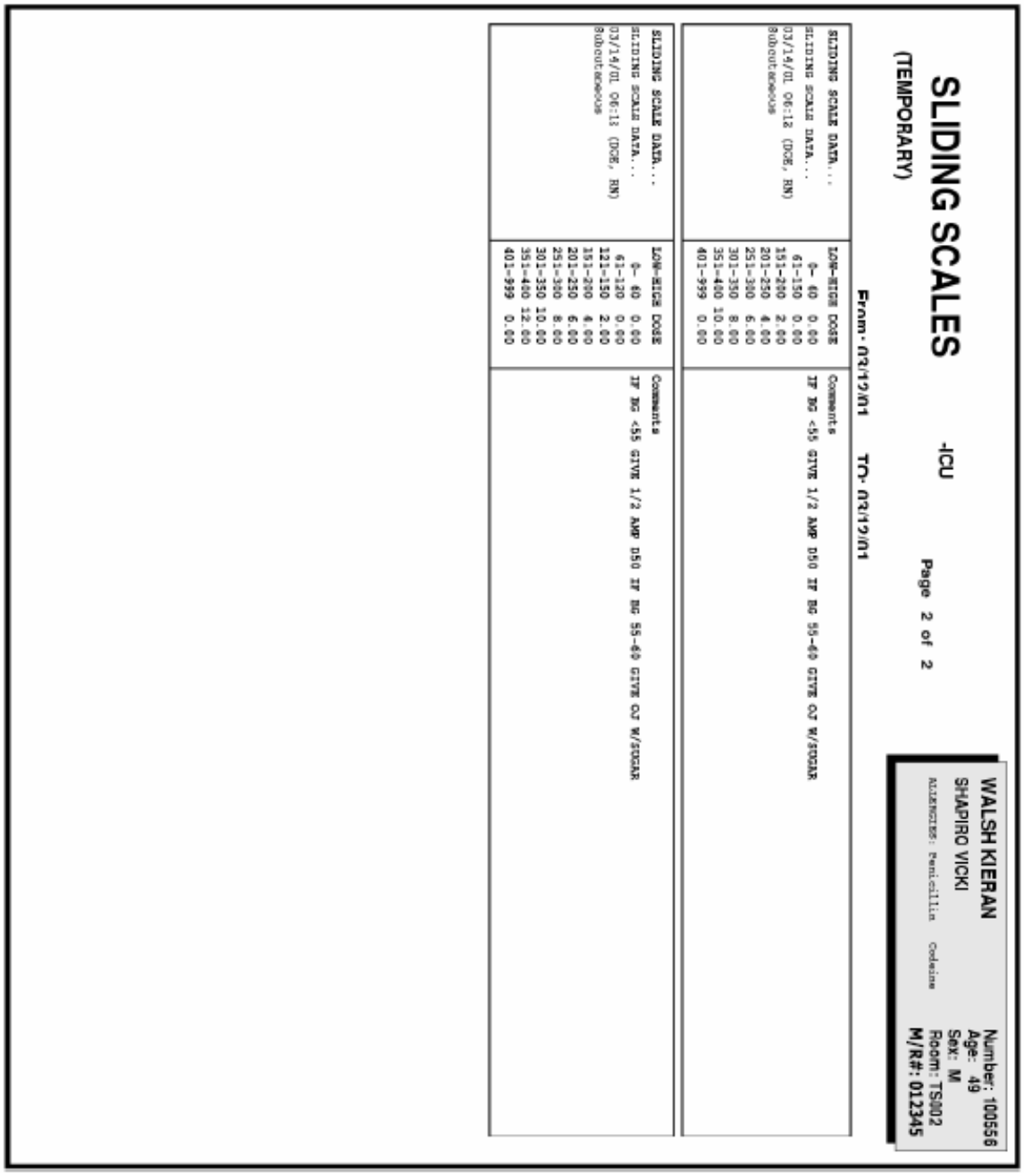


* indicates more than one result during this time period
^ indicates a blood glucose > 1000
○ or Plain text indicates Point of Care entry
● or Bold indicates Lab result

ICU Diabetic Flow Sheet - Final



ICU Diabetic Flow Sheet - Temporary Sliding Scales



SLIDING SCALES -ICU Page 2 of 2
(TEMPORARY)

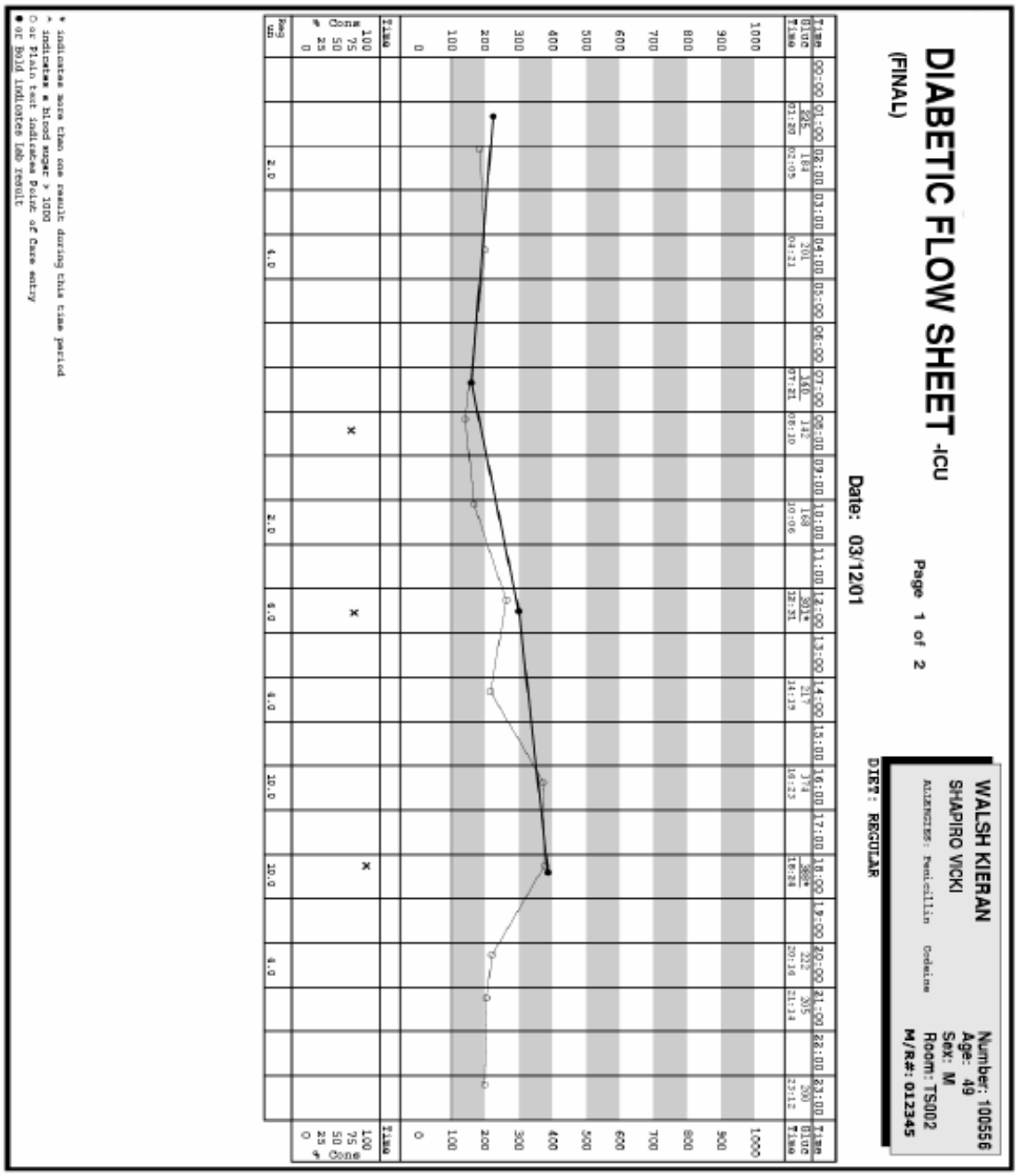
WALSH KIERAN
SHAPIRO VICKI
ALLERGIES: Penicillin Codeine
Number: 100556
Age: 49
Sex: M
Room: TS302
M/R#: 012345

From: 03/13/01 TO: 03/19/01

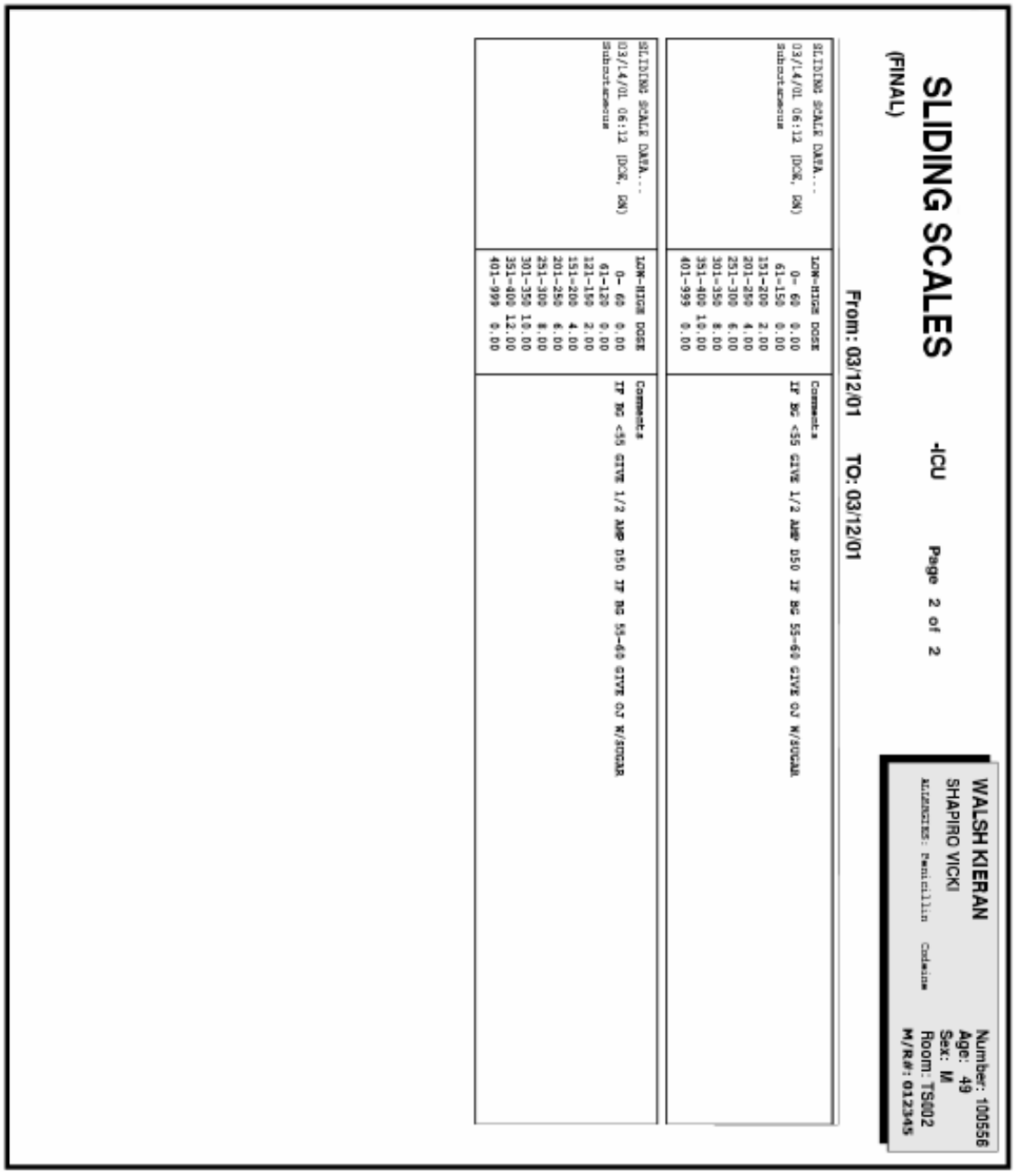
SLIDING SCALE DATA...	LOW-HIGH DOSE	Comments
SLIDING SCALE DATA...	0- 60 0.00	IF BG <55 GIVE 1/2 AMP D50 IF BG 55-60 GIVE OJ W/SUGAR
03/14/01 06:12 (DGE, RN)	61-150 0.00	
Subcutaneous	151-200 2.00	
	201-250 4.00	
	251-300 6.00	
	301-350 8.00	
	351-400 10.00	
	401-999 0.00	

SLIDING SCALE DATA...	LOW-HIGH DOSE	Comments
SLIDING SCALE DATA...	0- 60 0.00	IF BG <55 GIVE 1/2 AMP D50 IF BG 55-60 GIVE OJ W/SUGAR
03/14/01 06:18 (DGE, RN)	61-120 0.00	
Subcutaneous	121-150 2.00	
	151-200 4.00	
	201-250 6.00	
	251-300 8.00	
	301-350 10.00	
	351-400 12.00	
	401-999 0.00	

ICU Diabetic Flow Sheet - Final



ICU Diabetic Flow Sheet - Final Sliding Scales



SLIDING SCALES -ICU Page 2 of 2
(FINAL)

WALSH KIERAN
SHAPIRO VICKI
ALLERGIES: Penicillin Codeine
Number: 100556
Age: 49
Sex: M
Room: TS602
M/R#: 012345

From: 03/12/01 TO: 03/12/01

SLIDING SCALE DATA... 03/14/01 06:12 [DOR, SN] Subcutaneous	ICN-HIGH DOSE 0- 60 0.00 61-150 0.00 151-200 2.00 201-250 4.00 251-300 6.00 301-350 8.00 351-400 10.00 401-999 0.00	Comments IF BG <55 GIVE 1/2 AMP D50 IF BG 55-60 GIVE OJ W/SUGAR
SLIDING SCALE DATA... 03/14/01 06:12 [DOR, SN] Subcutaneous	ICN-HIGH DOSE 0- 60 0.00 61-120 0.00 121-150 2.00 151-200 4.00 201-250 6.00 251-300 8.00 301-350 10.00 351-400 12.00 401-999 0.00	Comments IF BG <55 GIVE 1/2 AMP D50 IF BG 55-60 GIVE OJ W/SUGAR

10.1 How to Print

The Diabetic Flow Sheet may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.

2. From the Virtual Chart select the appropriate tab.

3. Select **Diabetic Record Flowsheet**.

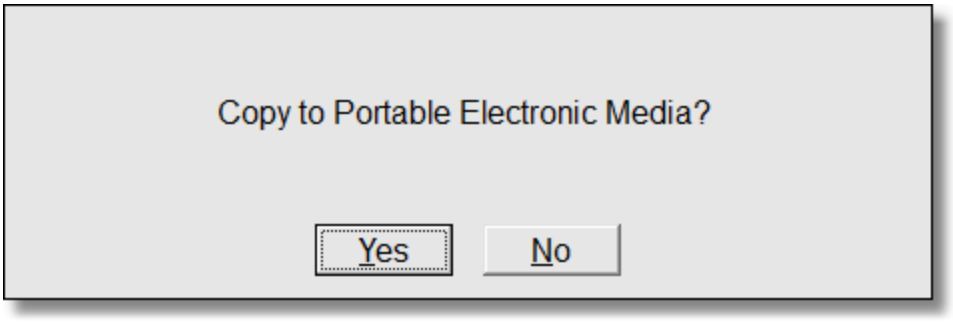
Chapter 11 Discharge Instructions

The Discharge Instructions is a document that includes the patient's diet, current medications and any other instructions pertinent to the patient's discharge status. They may be printed at anytime during the patient's stay, but it is primarily printed at patient discharge from hospital. Printing the Discharge Instructions is mandatory, unless otherwise specified by hospital policy. The report is usually a permanent part of the patient's chart.

11.1 How to Print

- From the Virtual Chart, select **Discharge Instructions Report**.
- Select **Cancel** to abort or enter the number of copies to print and select **OK**. A prompt to copy the report to portable electronic media will display.

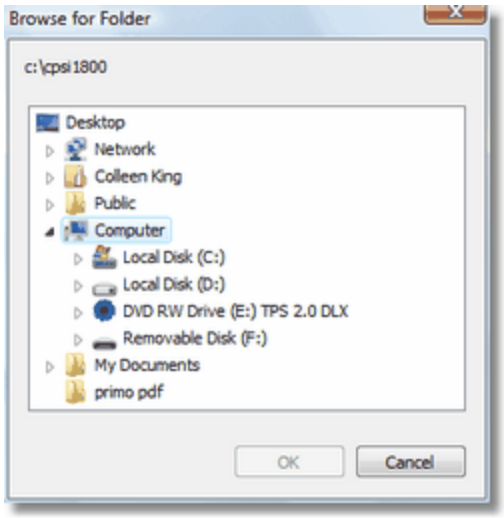
Select **POC Whiteboard** > **Patient** > **Discharge Instructions** > **1** > **OK**



Copy to Portable Electronic Media Prompt

- Select **No** to access the report as usual or **Yes** to create an electronic file. Windows explorer will display for selection of the device/folder.

Select **POC Whiteboard** > **Patient** > **Discharge Instructions Report** > **Copy Patient to Portable Media?** > **Yes**



Browse for Folder

- Select **Cancel** to abort the file transfer. To copy the report, select the file destination then **OK**.

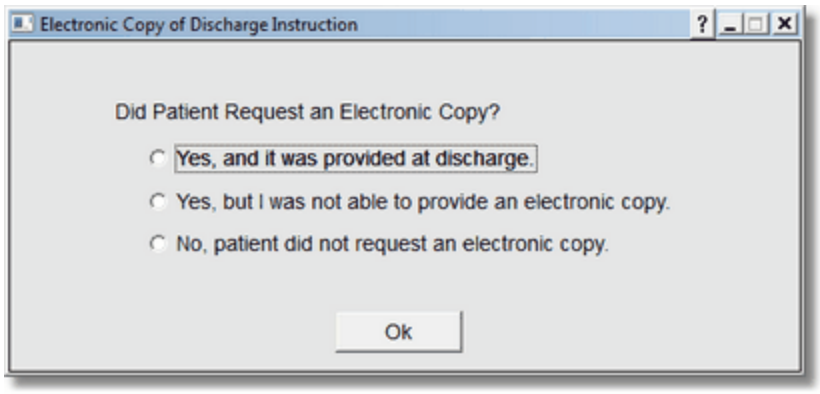
Select **POC Whiteboard** > **Patient** > **Discharge Instructions Report** > **Copy Patient to Portable Media?** > **Yes** > **Portable Media** > **OK**

Encryption Key Entry

- In order to copy the file, an encryption key must be entered. The patient will need this password to access the file. Enter the key then select **OK** to complete the file transfer. The Release of Information Log is automatically updated for the patient when the option to copy to portable media is processed.

- Whether Yes or No is selected when prompted to Copy to Portable Electronic Data, the system will display a prompt asking if the patient requested an electronic copy.

Select **POC Whiteboard** > **Patient** > **Discharge Instructions Report** > **Copy Patient to Portable Media?** > **Yes** > **Portable Media** > **OK** >**Encryption Key** > **OK**

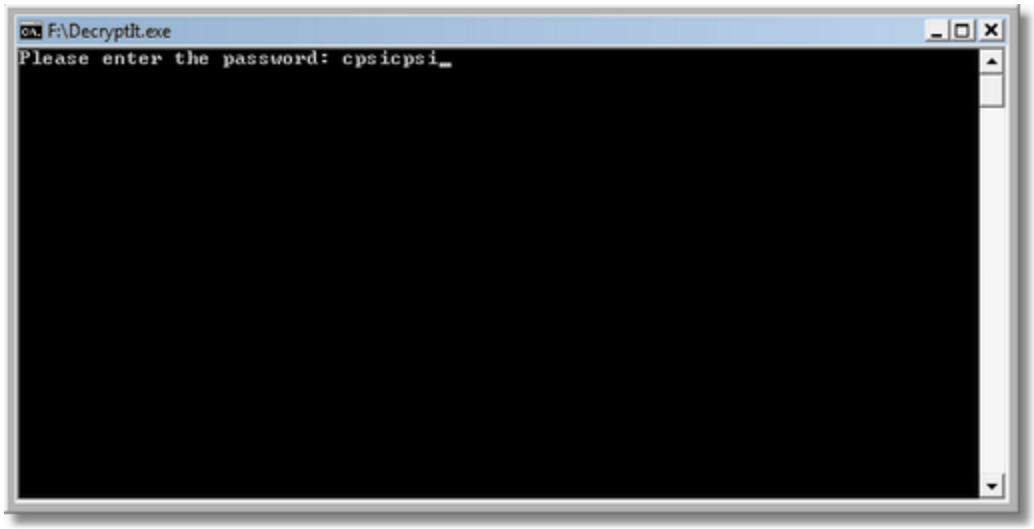


Electronic Copy of Discharge Instruction

- The designated number of copies will print to the default printer. To access the electronic version of the document at a later time, the patient will access the portable media device and select 

to enter the encryption key.

Select **Desktop** > **Computer** > **Removable Disk** > **DecryptIt**



Execute Decryption

- After the encryption key is entered, the PDF document can be opened as usual.

11.2 Description and Usage

The Discharge Instructions is a document that includes the patient's diet, current medications and any other instructions pertinent to the patient's discharge status. The Discharge Instructions are included in the Discharge Summary.

Discharge Instructions

Discharge Instructions

Discharge Instructions

As of 03/03/00 13:18 Page 1 of 1

WALSH KIERAN
SHAPIRO VICKI
ALLERGIES: Bactrim Penicillin
AGE: 49
SEX: M
ROOM: TS003
M/R#: 012345

DIET: 1800 CAL ADA.

MEDICATIONS

Name	Route
GLIPIZIDE(GLUCOTROL)TAB **Dose:** 5 MG **Frequency:** TAKE AS DIRECTED	**BY MOUTH** **Last Given:** 02/04 11:23
MVI(MULTIVITAMIN) CAP **Dose:** 1 TAB **Frequency:** TAKE AS DIRECTED	**BY MOUTH** **Last Given:** 02/04 12:15
ZITHROMAX TAB **Dose:** 250 MG **Frequency:** EVERY 6 HRS	**BY MOUTH** **Last Given:** 02/04 12:15

OTHER INSTRUCTIONS

Activity instructions:(state limitations) Activity as tolerated.
Follow-up care. See your physician on: Date _031100, Time _1230_.
Contact your physician if you experience any:
Pain, Numbness of extremities, Temperature over 101 degrees.
Personal items listed on adm. assessment returned to patient N/A.
Pre-admission medication returned: N/A.
Prescription(s) to patient: Yes.
Copy of instructions to patient/SO: Yes.
Patient/SO understands discharge instructions: Yes.
Special Instructions: _OK TO RETURN_TO_WORK_IN_4WKS_____.

*Patients's signature:*_____ *Nurse's signature:*_____

PATIENT:	WALSH KIERAN	NUMBER:	100524	AGE:	49	SEX:	M	ROOM:	TS003	PAGE:	1

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Displays patient's name, admitting physician, age, sex, room number, medical records number, and any drug allergies documented through the TruBridge EHR system. In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

- **Diet:** The patient's diet will display in the top left-hand corner of the report just below the header.

- **Medications:** Will display the description of the medications the patient is taking home, along with the dosage, frequency, and instructions. If Electronic Medication Reconciliation is utilized, medications will be sorted by the following categories:

- **Change**: Signifies that a home medication or an active medication that was associated with a home medication was continued at discharge but with modifications to the original order. The changed medication will be followed with up to four lines describing what has changed in relation to medication, dose, route and/or frequency.
  - **Continue**: Signifies that a home medication was continued at discharge.
  - **New**: Signifies that a medication has been ordered on discharge that the patient was not taking prior to the hospital stay.
  - **PLEASE STOP TAKING ALL MEDICATIONS LISTED BELOW: Stop**: Signifies that a home medication was discontinued at discharge.

- **Nursing Orders:** May be flagged to pull to this report. See Table Maintenance - Clinical User Guide for setup instructions.

NOTE: *The generic name for a medication will not display on the Discharge Instruction Report if the National Drug Code entered on the medication has been discontinued and is not currently assigned to another medication. If Patient Drug Information is set to auto-print with the Discharge Instruction Report, the drug monograph will display "No Drug Monograph Found" in place of the generic medication's monograph. Additionally, the Next Due Date/Time, new instruction fields and Prescription Details will generate on the report if the new Medication Reconciliation Application is utilized.*

NOTE: *The Discharge Instructions and Discharge Summary becomes "locked" 24 hours after both the Discharge Medication Reconciliation has been performed and the patient has been discharged from the hospital. Any changes changes made via Home Medications or Prescription Entry to the prescriptions (specifically to the "Instructions" or "Next Due date/time") do not reflect in the Discharge Instructions if 24 hours have passed.*

Chapter 12 Discharge Planner

The Discharge Planner is a document that includes financial and environmental concerns, expectations for discharge, potential for activities of daily living, etc. for the patient. It is included in the Initial Interview, can be printed at anytime during the patient's stay, but it is primarily printed if modifications are made to the Discharge Planner. The printing of the Discharge Planner is mandatory, unless otherwise specified by hospital policy. The report is usually a permanent part of the patient's chart.

12.1 How to Print

The Discharge Planner Report may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart select the appropriate tab.
3. Select **Discharge Planner Report**.

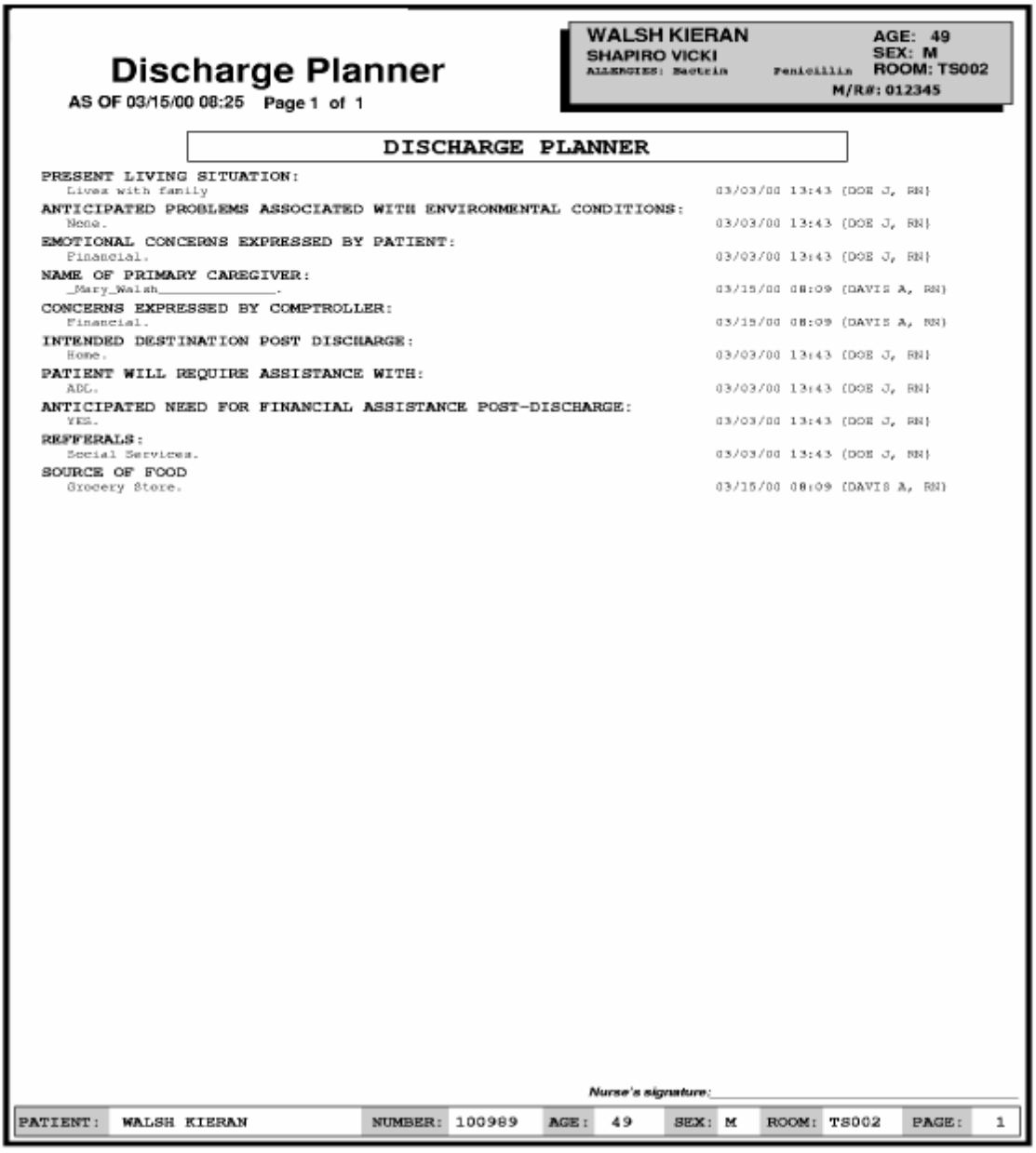
   System prompts "Include stricken/amended data?"
4. This will include stricken and amended data on the report.
5. Select a patient by choosing "This Department", "My Patients", or "Current Patients."
6. Click patient name and then "Add Selected" to add patient to Patient Selection List.
7. Select **Process**.

12.2 Description and Usage

The Discharge Planner is a document that includes financial and environmental concerns, expectations for discharge, potential for activities of daily living, etc. for the patient.

Discharge Planner

Discharge Planner



Discharge Planner
AS OF 03/15/00 08:25 Page 1 of 1

WALSH KIERAN
SHAPIRO VICKI
ALLERGIES: Bactrim Penicillin
AGE: 49
SEX: M
ROOM: TS002
M/R#: 012345

DISCHARGE PLANNER

PRESENT LIVING SITUATION:
Lives with family — 03/03/00 13:43 (DOE J, RN)

ANTICIPATED PROBLEMS ASSOCIATED WITH ENVIRONMENTAL CONDITIONS:
None. — 03/03/00 13:43 (DOE J, RN)

EMOTIONAL CONCERNS EXPRESSED BY PATIENT:
Financial. — 03/03/00 13:43 (DOE J, RN)

NAME OF PRIMARY CAREGIVER:
_Mary_Walsh_____. — 03/15/00 08:09 (DAVIS A, RN)

CONCERNS EXPRESSED BY COMPTROLLER:
Financial. — 03/15/00 08:09 (DAVIS A, RN)

INTENDED DESTINATION POST DISCHARGE:
Home. — 03/03/00 13:43 (DOE J, RN)

PATIENT WILL REQUIRE ASSISTANCE WITH:
ADL. — 03/03/00 13:43 (DOE J, RN)

ANTICIPATED NEED FOR FINANCIAL ASSISTANCE POST-DISCHARGE:
YES. — 03/03/00 13:43 (DOE J, RN)

REFFERALS:
Social Services. — 03/03/00 13:43 (DOE J, RN)

SOURCE OF FOOD
Grocery Store. — 03/15/00 08:09 (DAVIS A, RN)

*Nurse's signature:*_____

PATIENT: WALSH KIERAN | NUMBER: 100989 | AGE: 49 | SEX: M | ROOM: TS002 | PAGE: 1

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Displays patient's name, admitting physician, age, sex, room number, medical record number, and any drug allergies documented through the TruBridge EHR system. In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

- **Discharge Planner:** Displays 50 hospital-defined questions that can be answered to document a plan for the patient's discharge. The questions appear in bold text with the responses listed below. Once charted, the date, time, name, and title of the person who charted the information will be reflected.

- **Signature Line:** A signature line is provided in lower right-hand corner of the report.

Chapter 13 Discharge Summary

The Discharge Summary is a document that includes the patient's diet, current medications, other instructions, and any other information pertinent to the patient's discharge status. It can be printed at anytime during the patient's stay, but it is primarily printed at patient discharge from the hospital. Printing the Discharge Summary is mandatory, unless otherwise specified by hospital policy. The report is usually a permanent part of the patient's chart.

13.1 How to Print

The Discharge Summary Report may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart select the appropriate tab.
3. Select **Discharge Summary Report**.

   System prompts "Include stricken/amended data?"

4. This option will include any stricken or amended data in the report.

   System prompts "Enter Number of Copies to Print"

5. Enter the number of reports to print.
6. Select **OK.**

13.2 Description and Usage

The Discharge Summary is a document that includes the patient's diet, current medications, other instructions, and any other information pertinent to the patient's discharge status. It is part of the patient's permanent chart. The Discharge Instructions are included in the Discharge Summary.

Discharge Summary

Discharge Summary

Discharge Summary
Printed: 10/02/06 12:35 Page 1 of 2

BOLTZ CAROLYN AGE: 32
JAMES AUTRY, MD SEX: F
ROOM: 502
ALLERGIES: Penicillin Codeine M/R#: A12472

09/28/06 16:35 {JANE E DOE, RN} **DIET:**
Amended: 09/28/06 16:35 {JED, RN} ~~Regular diet.~~
Low Sodium diet.

MEDICATIONS

Name	Last Given

DARVOCET N-100
TAKE 1 TABLET EVERY 6 HOURS AS NEEDED FOR PAIN

PHENERGAN {PROMETHAZINE} TB
TAKE 1 TAB EVERY SIX HOURS AS NEEDED FOR NAUSEA AND VOMITING

OTHER INSTRUCTIONS

09/28/06 16:42 {JANE E DOE, RN} **ACTIVITY:**
UP AD LIB.

09/28/06 16:42 {JANE E DOE, RN} **FOLLOW UP VISIT:**
SEE DR BAXTER IN 1 WEEK

09/28/06 16:42 {JANE E DOE, RN} **Activity instructions {state limitations}:**
RESUME ACTIVITY AS TOLERATED

09/28/06 16:42 {JANE E DOE, RN} **Special instructions:**
Take medications as prescribed., Continue diet as instructed..

09/28/06 16:42 {JANE E DOE, RN} **Follow-up care. See your physician on:**
_10/02/06_0945_

09/28/06 16:42 {JANE E DOE, RN} **Contact your physician if you experience any:**
dizziness, pain UNCONTROLLED BY PAIN MEDICATION

09/28/06 16:42 {JANE E DOE, RN} **Personal items returned to patient:**
Yes.

09/28/06 16:42 {JANE E DOE, RN} **Transportation method:**
Wheelchair.

09/28/06 16:42 {JANE E DOE, RN} **Patient accompanied by:**
HUSBAND AND DAUGHTER

09/28/06 16:42 {JANE E DOE, RN} **Discharge disposition:**
Home.

09/28/06 16:42 {JANE E DOE, RN} **Condition of Surgical Incision:**
N/A.

09/28/06 16:42 {JANE E DOE, RN} **Afebrile:**
Yes.

09/28/06 16:42 {JANE E DOE, RN} **Pain Relief/PO Meds:**
Yes.

09/28/06 16:42 {JANE E DOE, RN} **Oriented:**
Yes.

09/28/06 16:42 {JANE E DOE, RN} **Appropriate Behavior:**
Yes.

09/28/06 16:42 {JANE E DOE, RN} **Ability to Function Independently:**
Yes.

09/28/06 16:42 {JANE E DOE, RN} **Hygiene:**
Self care, Skin good condition.

09/28/06 16:42 {JANE E DOE, RN} **Ambulation:**
Ambulatory.

09/28/06 16:42 {JANE E DOE, RN} **Disabilities:**
N/A.

09/28/06 16:42 {JANE E DOE, RN} **Impairments:**
N/A.

*Patients's signature:*_____ *Nurse's signature:*_____

PATIENT:	BOLTZ CAROLYN	NUMBER:	400675	AGE:	32	SEX:	F	ROOM:	502	PAGE:	1

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Displays patient's name, admitting physician, age, sex, room number, medical record number, and any drug allergies documented through the TruBridge EHR system. In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number, and page number will appear along the bottom edge of the page.

- **Diet:** The patient's diet will display in the top left-hand corner of the report just below the header, preceded by the date, time, name and title of the person who charted the information.

- **Medications:** Displays the description of the medications the patient is taking home, dosage, frequency, instructions, and date and time of last administration. If Electronic Medication Reconciliation is utilized, medications will be sorted by the following categories:
  - **Change**: Signifies that a home medication or an active medication that was associated with a home medication was continued at discharge but with modifications to the original order. The changed medication will be followed with up to four lines describing what has changed in relation to medication, dose, route and/or frequency.
  - **Continue**: Signifies that a home medication was continued at discharge.
  - **New**: Signifies that a medication has been ordered on discharge that the patient was not taking prior to the hospital stay.
  - **Stop**: Signifies that a home medication was discontinued at discharge.

  Additionally, The Next Due Date/Time, new instruction fields and Prescription Details will generate on the report if the new Medication Reconciliation Application is utilized.

- **Other Instructions:** Up to 30 hospital-defined questions that can be answered to detail the instructions given to the patient. The questions appear in bold text with the responses listed below. Once charted, the date, time, name, and title of the person who charted the information will be reflected. This section of instructions also prints on the Discharge Instructions report.

- **Other Information:** Up to thirty hospital-defined questions that can be answered to describe other pertinent patient information . The questions appear in bold text with the responses listed below. Once charted, the date, time, name, and title of the person who charted the information will be reflected. This section of information will ONLY print on the Discharge Summary report.

- **Signature Lines:** Signature lines are located at the bottom of the report for the patient and the nurse providing the care.

- **Nursing Orders:** May be flagged to pull to this report. See Table Maintenance - Clinical User Guide for setup instructions.

NOTE: *The Discharge Instructions and Discharge Summary becomes "locked" 24 hours after both the Discharge Medication Reconciliation has been performed and the patient has been discharged from the hospital. Any changes made via Prescription Entry to the prescriptions (specifically to the "Instructions" or "Next Due date/time") do not reflect in the Discharge Instructions if 24 hours have passed.*

Chapter 14 Education

The Education report is a document that includes multi-disciplinary information on how and when the patient was educated regarding diagnosis, medication administration, etc. The report can be printed at anytime during the patient's stay by the nursing staff, but the nurse assigned to the patient primarily prints it, or staff who make modifications to the report. Printing the Education report is optional, unless otherwise specified by hospital policy. The report is usually not a permanent part of the patient's chart.

14.1 How to Print

The Education Report may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart select the appropriate tab.
3. Select **Education Report**.

   System prompts, "Include stricken/amended data?"
4. This will include stricken and amended data in the report
5. Click a document name and then "Add Selected" to add document to Document Selection List
6. Select **Process**.

   System prompts, "Select Starting Point."
7. Enter the dates that the reports is needed.
8. Select **Print**.

14.2 Description and Usage

The Education report is a document that includes multi-disciplinary information on how and when the patient was educated regarding diagnosis, medication administration, etc.

Education

Education Report

EDUCATION

FROM: 03/16/00 07:00 TO: 03/16/00 10: Page 1 of 1

WALSH KIERAN
SHAPIRO VICKI
ALLERGIES: Bactrim Penicillin
AGE: 49
SEX: M
ROOM: TS002
M/R#: 012345

DIABETES

PATIENT INSTRUCTED ON:
03/16/00 09:57 [DOE, RN] Signs and Symptoms, Warning Signs of High/Low Blood Sugar, Blood Glucose Values, Insulin Administration, Action of Insulin, Insulin Storage, Insulin Site Rotation, Diet after Discharge, Pt Verbalizes Understanding.

EDUCATION DOCUMENTATION GIVEN TO:
03/16/00 09:57 [DOE, RN] Patient, Significant Other.

CARDIOPULMONARY

PATIENT INSTRUCTED ON:
03/16/00 09:58 [DOE, RN] Home Ventolin Use, Oxygen Use at Home, Deep Breathing and Coughing Techniques, Use of the Incentive Spirometer, Pt Verbalizes Understanding.

EDUCATION DOCUMENTATION GIVEN TO:
03/16/00 09:58 [DOE, RN] Patient, Significant Other.

PATIENT/FAMILY DEMONSTRATES:
03/16/00 09:58 [DOE, RN] Ability to Administer Respiratory Treatments, Deep Breathing and Coughing Techniques, Proper Use of the Incentive Spirometer.

POST-OP INSTRUCTIONS

PATIENT INSTRUCTED ON:
03/16/00 10:29 [DOE, RN] turn, cough, deep breathing, splinting incision when coughing, leg exercises

POST-OP PAIN MANAGEMENT:
03/16/00 10:29 [DOE, RN] reviewed pain meds, instructed on relaxation techiques, positioning for comfort.

ACTIVITY LIMITS:
03/16/00 10:29 [DOE, RN] understands activity limits, knows importance of early ambulation, do not lift more than 20 lbs.

CARE OF INCISION:
03/16/00 10:29 [DOE, RN] keep dressing clean and dry, cleanse wound with peroxide____, change dressing daily w/ sterile tech.

Nurse's signature:_____ Validated by:_____

PATIENT:	WALSH KIERAN	NUMBER:	100989	AGE:	49	SEX:	M	ROOM:	TS002	PAGE:	1

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Displays patient's name, admitting physician, age, sex, room number, medical record number, and any drug allergies documented through the TruBridge EHR system. In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

- **Education Categories:** Each category will be highlighted with bold text within a shaded gray box. There are 34 categories that are all user-defined and can be set up for multi-discipline use. Within the category up to thirty hospital-defined questions with up to twelve answers for each can be set up. The questions appear in bold text with the responses listed below. Under each category, entries made will display in chronological order preceded by the date, the time entry made, and name and title of individual that entered the information. Education questions can be integrated with the Physical Assessment and Initial Interview portions of the chart and will display on the Education report. Information charted in Initial interview, Discharge Planner, and Discharge Summary and Instructions can be set to print on the Education reports. This is done through Point of Care setup for each application. Refer to the Point of Care setup reference manual for setting this option.

- **Entries:** Each entry will fall under the appropriate category

Chapter 15 End of Shift

Please refer to the POC User Guide for information on this topic.

Chapter 16 Fax Status Report

This report can be useful in monitoring fax usage to particular locations and used to troubleshoot failed fax problems.

The Fax Status Report:

- Provides the date and time of the fax transmission, the destination and fax number, the initials or initials/employee number of the sender, and status of each fax transmission.
- Includes a description of the document transmitted.
- Includes an option to print a list of either all fax transmissions, successful transmissions, or failed fax transmissions and can be sorted by destination, time, or sender.

There are two versions of the Fax Status Report.

- Departmental Fax Status Report (includes fax transmission information for the login department)

Fax Status Report (Department)

1. The system will default to the current date. Press <Enter> for the current date, or type the desired date.
2. The system will prompt for the fax transmissions to be included. Enter **A-All** for all transmissions, **S-Successful** for successful transmissions or **F-Failed** for failed transmissions.
3. The system will prompt for the order in which they will sort and be printed. Enter **T-Time** to sort and print by time, **D-Destination Number** to sort by and print by destination number, **N-Name of Destination** to sort and print by Destination name or **S-Sender** to sort and print by sender.

Q. HOW OFTEN SHOULD THIS REPORT BE PRINTED?
A. As often as needed.

Q. WHO SHOULD PRINT THIS REPORT?
A. Ancillary department managers.

16.1 How to Print

The Fax Status Report may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart select the appropriate tab.

3. Select **Fax Status Report**.

   System Prompts, "Status Report"

4. Enter the As of Date, Types of Faxes and Fax Order.

5. Select **Print**.

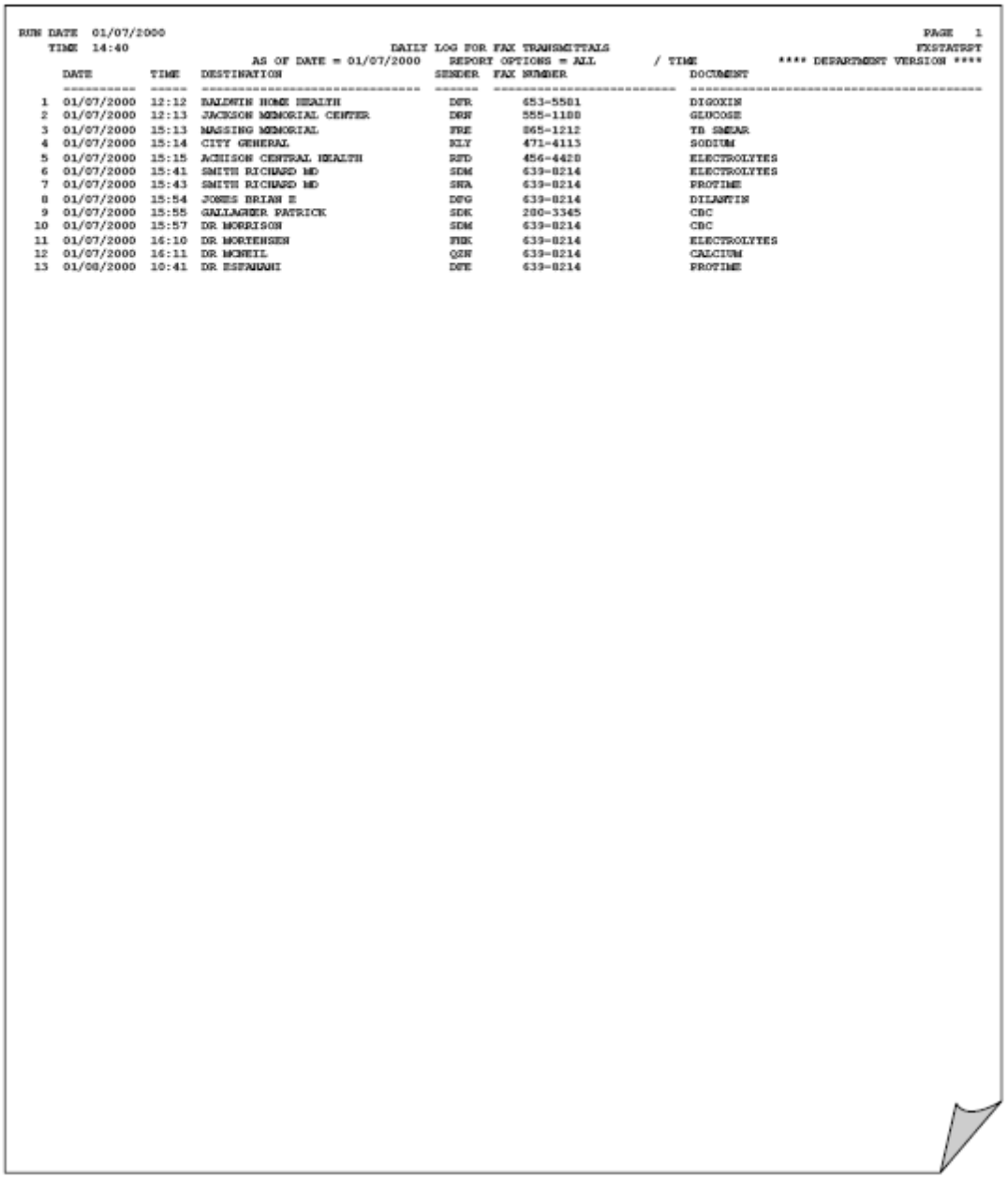
16.2 Description and Usage

This report can be useful in monitoring usage by department to particular locations and be used to troubleshoot failed fax problems. The Fax Status report by Department includes all fax transmissions sent by the login department and will provide the following:

- Date and time the fax transmission was initiated, the destination and fax number, the initials or initials/employee number of the sender, and the status of each fax transmission.
- Description of the document sent.
- Option to print a list of either all fax transmission, successful transmission, or failed fax transmission and can be sorted by destination, time, or sender.

Fax Status Report

Daily Log for Fax Transmittals



RUN DATE 01/07/2000 PAGE 1
TIME 14:40 DAILY LOG FOR FAX TRANSMITTALS FXSTATRPT
AS OF DATE = 01/07/2000 REPORT OPTIONS = ALL / TIME **** DEPARTMENT VERSION ****

	DATE	TIME	DESTINATION	SENDER	FAX NUMBER	DOCUMENT
1	01/07/2000	12:12	BALDWIN HOME HEALTH	DPR	653-5581	DIGOXIN
2	01/07/2000	12:13	JACKSON MEMORIAL CENTER	DRW	555-1188	GLUCOSE
3	01/07/2000	15:13	MASSING MEMORIAL	FRE	865-1212	TB SMEAR
4	01/07/2000	15:14	CITY GENERAL	RLY	471-4113	SODIUM
5	01/07/2000	15:15	ACHISON CENTRAL HEALTH	RTD	456-4420	ELECTROLYTES
6	01/07/2000	15:41	SMITH RICHARD MD	SDM	639-8214	ELECTROLYTES
7	01/07/2000	15:43	SMITH RICHARD MD	SNA	639-8214	PROTIME
8	01/07/2000	15:54	JONES BRIAN E	DPG	639-8214	DILANTIN
9	01/07/2000	15:55	GALLAGHER PATRICK	SDK	200-3345	CBC
10	01/07/2000	15:57	DR MORRISON	SDM	639-8214	CBC
11	01/07/2000	16:10	DR MORTENSEN	FBK	639-8214	ELECTROLYTES
12	01/07/2000	16:11	DR MCNEIL	QZW	639-8214	CALCIUM
13	01/08/2000	10:41	DR ESFANANI	DPE	639-8214	PROTIME

Listed below is an explanation of each column.

- **As of Date:** This is the print date.
- **Report Options =** When generating the report, users have the ability to select among including all faxes, failed faxes or successful faxes.
- **/ Time:** During report generation, users may list each fax in order by destination number, name of destination, sender or time.
- **Date:** Lists the date the fax was sent
- **Time:** The time the fax was sent is listed in this column.
- **Destination:** Displays the fax's destination
- **Sender:** Displays the sender's initials
- **Fax Number:** Includes the destination fax number
- **Document:** Displays the type of document sent

Chapter 17 Floor Stock Report

Please refer to the Patient Account Detail Report - Floor Stock Report 129.

Chapter 18 Flowchart Reflex Report

The Flowchart Reflex Report is a document that includes reflex responses that have been generated for specific flowcharts. It can be printed at anytime during the patient's stay by the nursing staff. Printing the Flowchart Reflex Report is optional, unless otherwise specified by hospital policy.

18.1 How to Print

The Flowchart Reflex Report may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart select the appropriate tab.
3. Select **Flow Chart Reflex Report**.
4. Choose a date range to print the report for
5. Select a flowchart to print

   System prompts "Print Declined Reflex Responses?"
6. This will add any declined reflex responses to the report.

18.2 Description and Usage

The Flowchart Reflex Report is a document that includes reflex responses that have been generated for specific flowcharts.

Flowchart Reflex Report

Flowchart Reflex Report

REFLEX REPORT

Flowchart: CHEST PAIN - ER TRIAGE
N/A Started 06/05/05 Page 1
From: 06/07/05 To: 06/07/05

BOLTZ CAROLYN
ROGERS RYAN L
ALLERGIES: Penic Codeine
AGE: 60
SEX: F
ROOM: 002
M/R#: 235689

06/07/05

12:48	(JJD, RN)	Create Order	MORPHINE : 1MGML	Sent
12:48	(JJD, RN)	Create MEDACT Order	COMPLETE BED REST	Sent
12:48	(JJD, RN)	Create MEDACT Order	ADMIT TO TELEMETRY	Sent
12:48	(JJD, RN)	Create Order	LANOXIN (DIGOXIN) TB : 125MCG	Sent
12:48	(JJD, RN)	Create MEDACT Order	CARDIAC MONITORING: DOCUMENT RHYTHM	Sent
12:48	(JJD, RN)	Create Order	ASPIRIN TAB : EC	Sent
12:48	(JJD, RN)	Create Order	CT CHEST WITH CONTRAST	Sent
12:48	(JJD, RN)	Create Order	POTASSIUM SERUM *	Sent
12:48	(JJD, RN)	Create Order	NORMAL SALINE	Sent

PATIENT: BOLTZ CAROLYN NUMBER: 356959 AGE: 60 SEX: F ROOM: 002 PAGE: 1

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Displays patient name, age, sex, account number, admitting physician, room number, medical record number, and any drug allergies documented through the TruBridge EHR system.
- **Reflex Report:** Displays flowchart name, date started, date range for printing, time reflex responses generated, initials and credentials of who sent the responses, and reflex responses will list as well as the status

Chapter 19 Graphic I&O

The Graphic I & O is a document that includes the patient's vital signs, weight, diet information, and intake and output chart over a three-day period. It can be printed at anytime during the patient's stay, but should be printed at the end of each shift or automatically at a specific hour, once a day. The nursing staff can print the report, but the nurse assigned to the patient primarily prints it or it is set up to automatically print at a specific hour. Printing the Graphic I & O is mandatory, unless otherwise specified by hospital policy. The report is usually a permanent part of the patient's chart.

19.1 How to Print

The Graphic I & O may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.

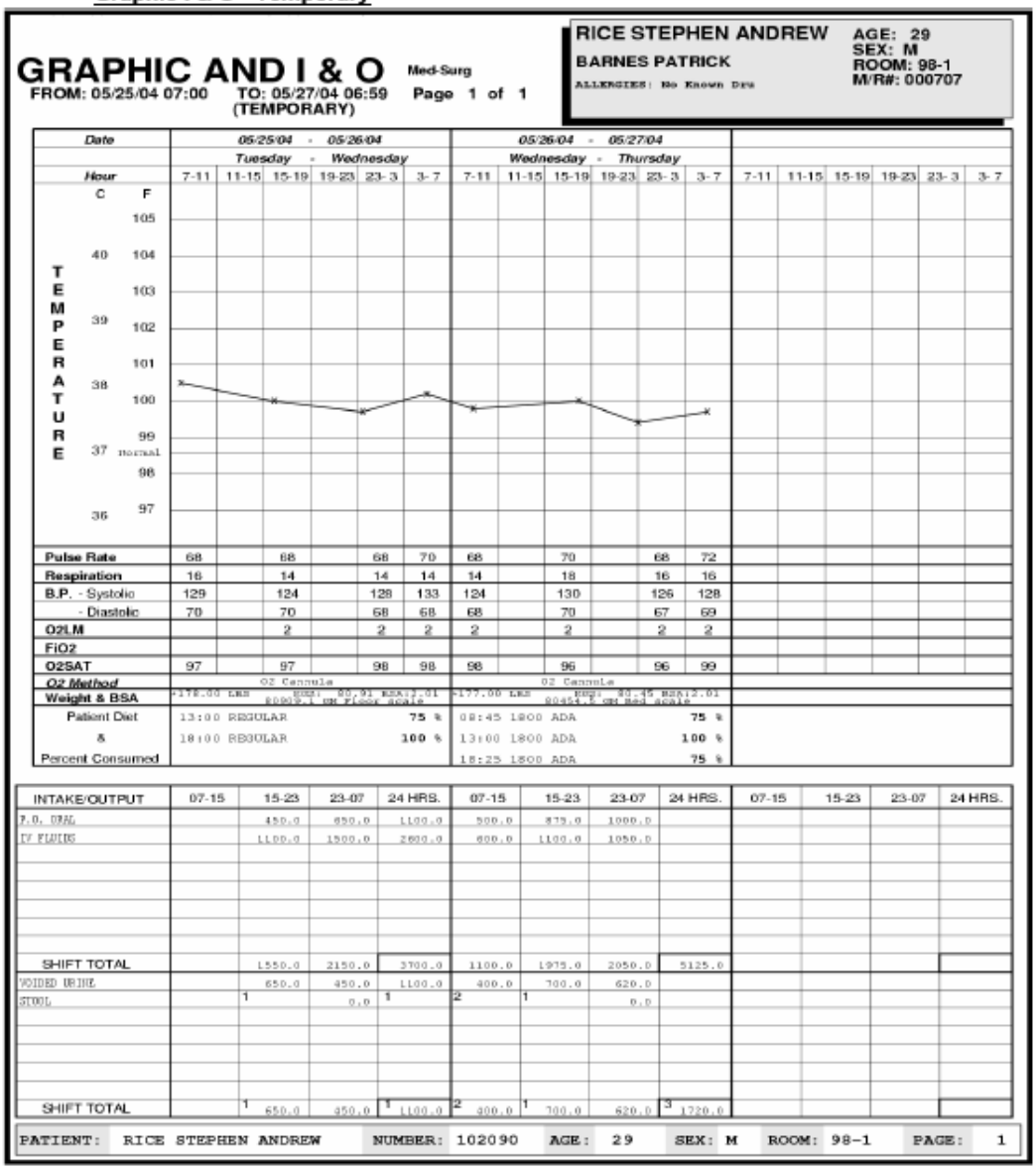
2. From the Virtual Chart select the appropriate tab.

3. Select **Graphic I & O**.

19.2 Description and Usage

The Graphic I & O is a document that includes the patient's vital signs, weight, diet information, and intake and output chart over a three-day period. The forms print as "Temporary" until three days of information is completed. After three days, the report prints as "Final," It is a part of the patient's permanent chart.

Graphic I & O - Temporary



Graphic I & O - Temporary

GRAPHIC AND I & O Med-Surg
FROM: 05/25/04 07:00 TO: 05/27/04 06:59 Page 1 of 1
(TEMPORARY)

RICE STEPHEN ANDREW AGE: 29
BARNES PATRICK SEX: M
ALLERGIES: No Known Drs ROOM: 98-1
M/R#: 000707

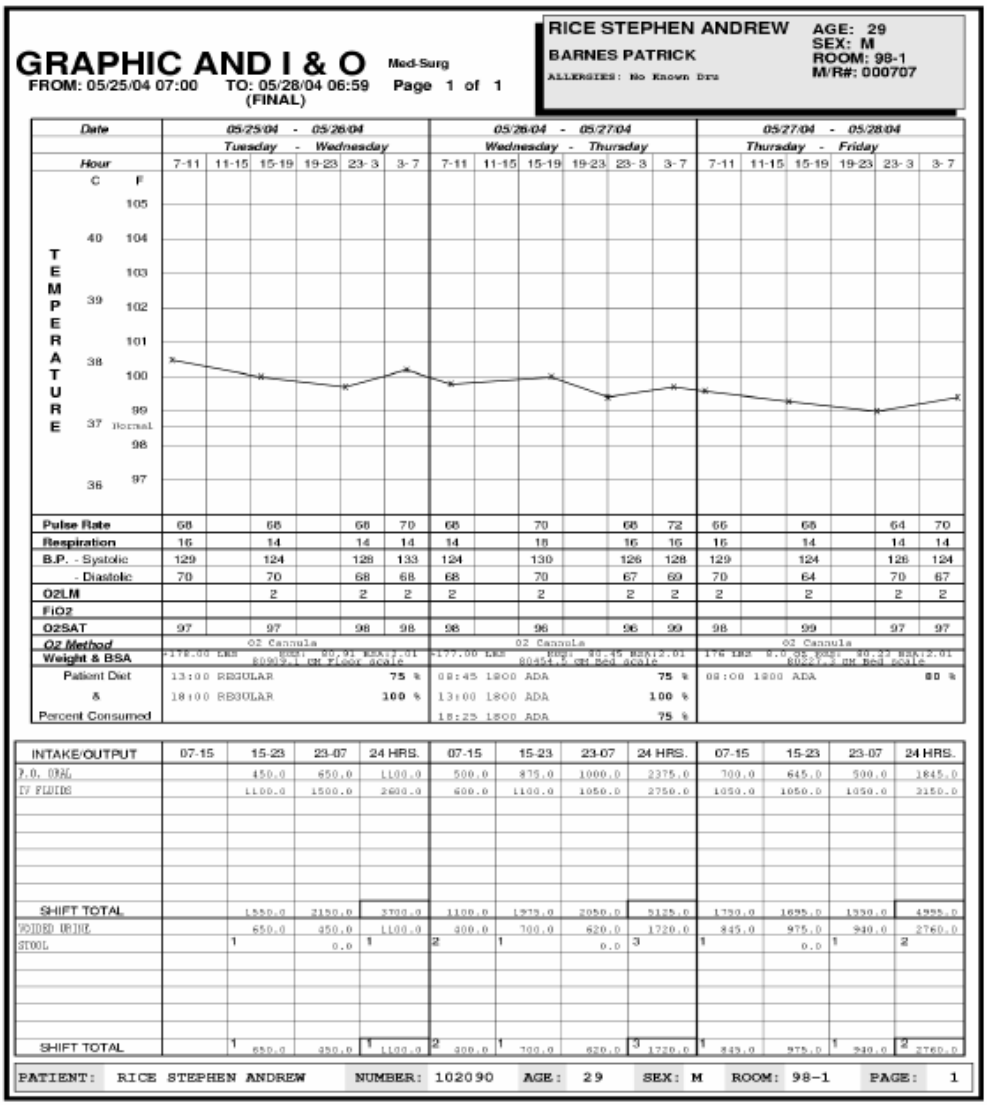
Date	05/25/04 - 05/26/04 Tuesday - Wednesday						05/26/04 - 05/27/04 Wednesday - Thursday											
Hour	7-11	11-15	15-19	19-23	23-3	3-7	7-11	11-15	15-19	19-23	23-3	3-7	7-11	11-15	15-19	19-23	23-3	3-7
TEMPERATURE C F																		
Pulse Rate	68		68		68	70	68		70		68	72						
Respiration	16		14		14	14	14		18		16	16						
B.P. - Systolic	129		124		128	133	124		130		126	128						
- Diastolic	70		70		68	68	68		70		67	69						
O2LM			2		2	2	2		2		2	2						
FiO2																		
O2SAT	97		97		98	98	98		96		96	99						
O2 Method			O2 Cannula						O2 Cannula									
Weight & BSA	+178.00 LBS		WGHT 90.91 BSA:2.01				+177.00 LBS		WGHT 90.45 BSA:12.01									
Patient Diet	13:00 REGULAR					75 %	08:45 1800 ADA					75 %						
&	18:00 REGULAR					100 %	13:00 1800 ADA					100 %						
Percent Consumed							18:25 1800 ADA					75 %						

INTAKE/OUTPUT	07-15	15-23	23-07	24 HRS.	07-15	15-23	23-07	24 HRS.	07-15	15-23	23-07	24 HRS.
P.O. ORAL		450.0	850.0	1100.0	500.0	875.0	1000.0					
IV FLUIDS		1100.0	1300.0	2600.0	600.0	1100.0	1050.0					
SHIFT TOTAL		1550.0	2150.0	3700.0	1100.0	1975.0	2050.0	5125.0				
VOIDED URINE		650.0	450.0	1100.0	400.0	700.0	620.0					
STOOL		1 0.0		1	2	1	0.0					
SHIFT TOTAL		1 650.0	450.0	1 1100.0	2 400.0	1 700.0	620.0	3 1720.0				

PATIENT: RICE STEPHEN ANDREW NUMBER: 102090 AGE: 29 SEX: M ROOM: 98-1 PAGE: 1

Graphic I & O - Final

Graphic I&O – FINAL



GRAPHIC AND I & O Med-Surg
FROM: 05/25/04 07:00 TO: 05/28/04 06:59 Page 1 of 1
(FINAL)

RICE STEPHEN ANDREW AGE: 29
SEX: M
BARNES PATRICK ROOM: 98-1
ALLERGIES: No Known Drs M/R#: 000707

Date	05/25/04 - 05/26/04 Tuesday - Wednesday						05/26/04 - 05/27/04 Wednesday - Thursday						05/27/04 - 05/28/04 Thursday - Friday					
Hour	7-11	11-15	15-19	19-23	23-3	3-7	7-11	11-15	15-19	19-23	23-3	3-7	7-11	11-15	15-19	19-23	23-3	3-7
Pulse Rate	68		68		68	70	68		70		68	72	66		68		64	70
Respiration	16		14		14	14	14		18		16	16	16		14		14	14
B.P. - Systolic	129		124		128	133	124		130		126	128	129		124		126	124
- Diastolic	70		70		68	68	68		70		67	69	70		64		70	67
O2LM			2		2	2	2		2		2	2	2		2		2	2
FiO2																		
O2SAT	97		97		98	98	98		96		96	99	98		99		97	97
O2 Method			O2 Cannula						O2 Cannula						O2 Cannula			
Weight & BSA	178.00 LBS		BSA: 2.01 BMI: 30.91 80909.1 GM Floor scale				177.00 LBS		BSA: 2.01 BMI: 30.45 80454.5 GM Bed scale				176 LBS		BSA: 2.01 BMI: 30.23 80267.3 GM Bed scale			
Patient Diet	13:00 REGULAR					75 %	08:45 1800 ADA					75 %	08:00 1800 ADA					80 %
&	18:00 REGULAR					100 %	13:00 1800 ADA					100 %						
Percent Consumed							18:25 1800 ADA					75 %						

INTAKE/OUTPUT	07-15	15-23	23-07	24 HRS.	07-15	15-23	23-07	24 HRS.	07-15	15-23	23-07	24 HRS.
P.O. ORAL		450.0	650.0	1100.0	500.0	875.0	1000.0	2375.0	700.0	645.0	500.0	1845.0
IV FLUIDS		1100.0	1500.0	2600.0	600.0	1100.0	1050.0	2750.0	1050.0	1050.0	1050.0	3150.0
SHIFT TOTAL		1550.0	2150.0	3700.0	1100.0	1975.0	2050.0	5125.0	1750.0	1695.0	1550.0	4995.0
VOIDED URINE		650.0	950.0	1100.0	300.0	700.0	620.0	1720.0	845.0	975.0	940.0	2760.0
STOOL		1	0.0	1	2	1	0.0	3	1	0.0	1	2
SHIFT TOTAL		1 650.0	950.0	1 1100.0	2 300.0	1 700.0	620.0	3 1720.0	1 845.0	975.0	1 940.0	2 2760.0

PATIENT: RICE STEPHEN ANDREW NUMBER: 102090 AGE: 29 SEX: M ROOM: 98-1 PAGE: 1

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Displays patient's name, admitting physician, age, sex, room number, medical record number, and any drug allergies documented through the TruBridge EHR system. In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

- **Vital Signs:** Each 24-hour period is divided into four-hour intervals. The temperature is reflected in a line graph format. Pulse, respiration, blood pressure, O2, O2 L/Min, FiO2, and O2 Sat are reflected in numeric values below the graph. Weight is reflected in both pounds and kilograms along with the patient's body-surface area.

NOTE: *An asterisk (*) denotes multiple values have been charted. The most recent value prints, with previous values listed in the Patient Progress Notes.*

- **Patient Diet & Percent Consumed:** Displays up to three diet entries within a 24 hour period. Will also display diet description, percentage consumed, and time the entry was charted.

- **Breast Feeding:** Displays for Pediatric and Nursery chart types only. Will print the breast feeding time, minutes and totals for L, R, L/R breast.

NOTE: *If percentage of diet consumed has been charted on a diet through the Medact, the Breast Feeding section will not print on the report.*

- **Intake and Output Record:** The intake and output volumes reflect totals per shift, and a 24-hour total. The values are charted by frequency and display in the top left-hand corner of the boxes where volume entries also display. The intake displays up to ten categories. Any entries beyond that will be reflected under "Other" and will be detailed on the Patient Progress Notes. The output displays up to eight categories. Any entries beyond that will be reflected under "Other" and will be detailed on the Patient Progress Notes. There is an option to use eight or twelve hour I&O total in control table.

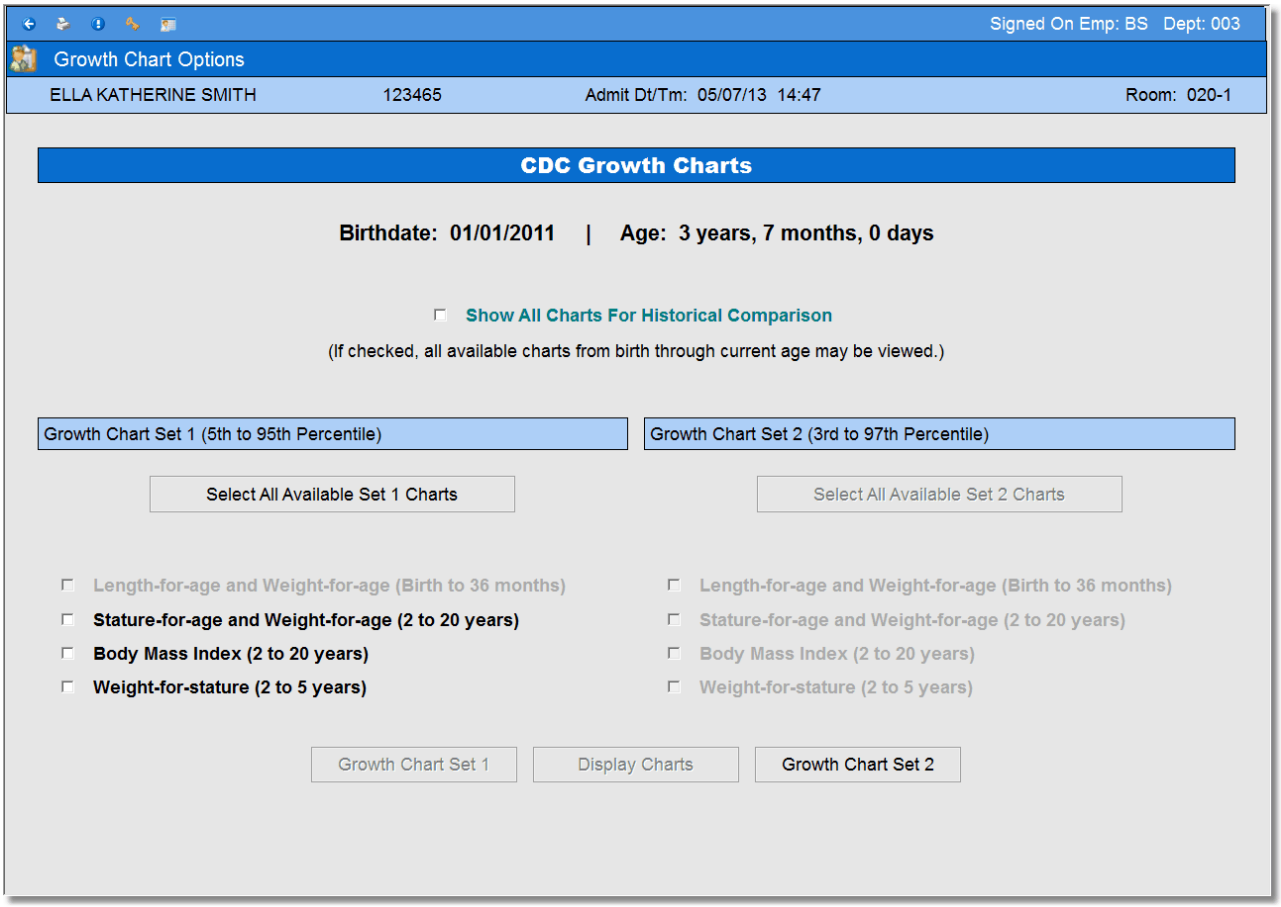
Chapter 20 Growth Charts

Growth Charts consist of a series of percentile curves that illustrate the distribution of selected body measurements in children. Growth charts are tools that contribute to forming an overall clinical impression for the child being measured. Growth charts can be added to Virtual Chart tab and printed at any time.

20.1 How to Print

The Growth Chart may be viewed by selecting the Growth Chart option from a virtual chart tab.

1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart select the appropriate tab.
3. Select the Growth Charts (All) to view the available Growth Charts.
4. To view all available Growth Charts that exist for the patient select the Check Box next to Show All Charts For Historian Comparison.
5. Set the report generation options that are needed for the report. Once all options have been selected, select Display Charts.



POC Growth Chart

20.2 Description and Usage

Various growth charts, including WHO Growth Charts, are available depending upon the patient's age range and gender. Weight and height must be present on the account in order for the growth charts to be accessible. Head circumference must be present for WHO Growth Charts. Physicians will have the ability to view historical growth charts: all charts from birth through the current age. Additionally, two different growth charts (5th to 95th Percentile and 3rd to 97th Percentile) are selectable, either for the current age or to include historical weight and height entries. Growth Chart functionality is now in ClientWare 5.

Data included on the Growth Charts is outlined below:

Birth to 36 Months

- 5 - 95 Percentile Length and Weight Growth Chart for the sex of the patient
- 3 - 97 Percentile Length and Weight Growth Chart for the sex of the patient

2 Years to 5 Years

- Weight for Stature Growth Chart for the sex of the patient

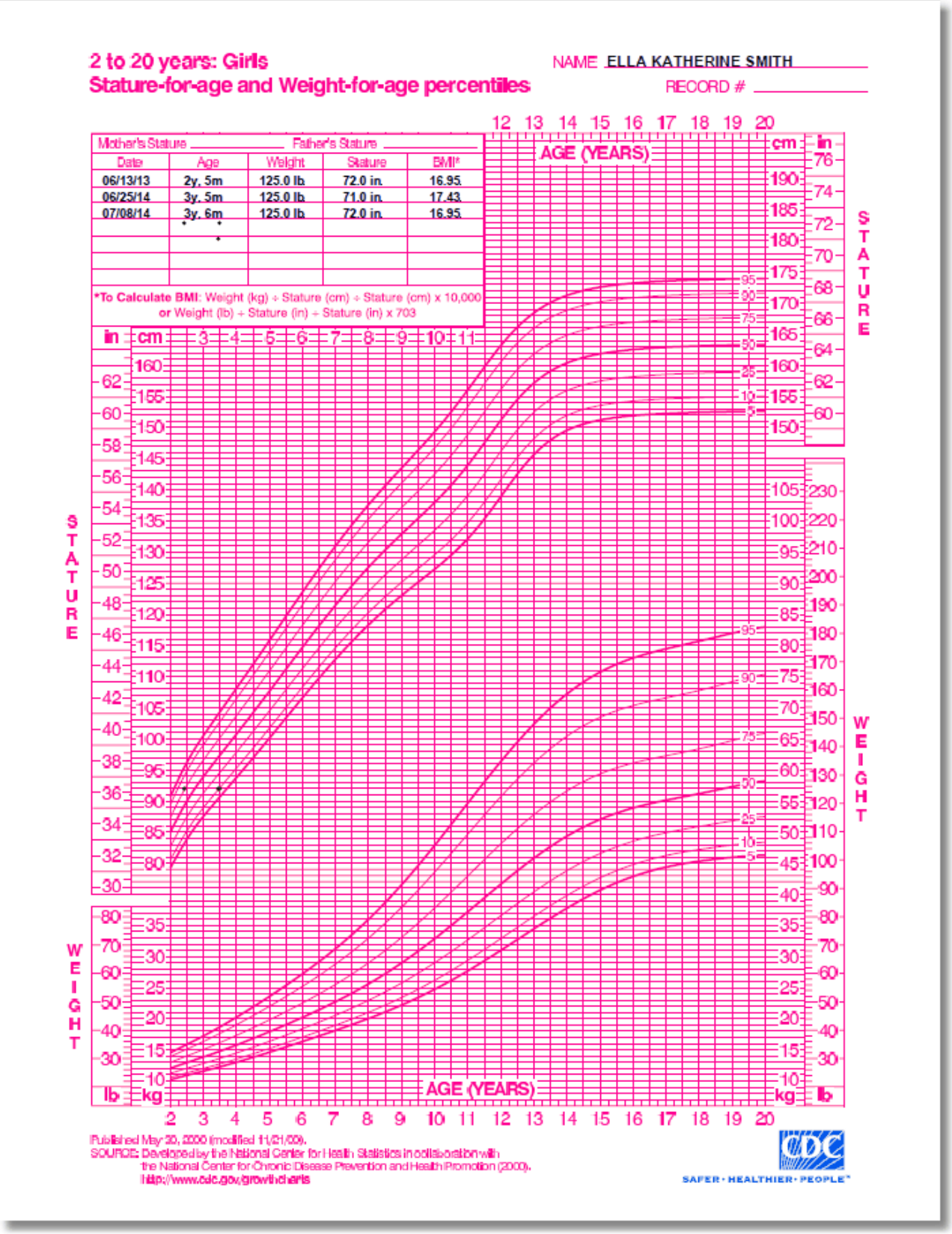
2 Years to 20 Years

- 5 - 95 Percentile Stature Growth Chart for the sex of the patient
- 5 - 95 Percentile BMI Growth Chart for the sex of the patient
- 3 - 97 Percentile Stature Growth Chart for the sex of the patient
- 3 - 97 Percentile BMI Growth Chart

WHO Birth to 24 Months

- Length-for-age and Weight-for-age percentiles
- Head Circumference-for-age and Weight-for-length percentiles
- The following is a full display of a **Growth Chart**.

Growth Chart



Chapter 21 Initial Interview

The Initial Interview is a document that includes information regarding the patient's demographics, pertinent history, and discharge planning. It can be printed at anytime during the patient's stay, but should be primarily printed after completion on the system. If modifications are made, the report should be printed again. The nursing staff can print the report, but the nurse assigned to the patient primarily prints it or staff who make modifications to the report. Printing the Initial Interview is mandatory, unless otherwise specified by hospital policy. The report is usually a permanent part of the patient's chart.

21.1 How to Print

The Initial Interview Report may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.

2. From the Virtual Chart select the appropriate tab.

3. Select **Initial Interview Report**.

   System prompts "Include stricken/amended data?"

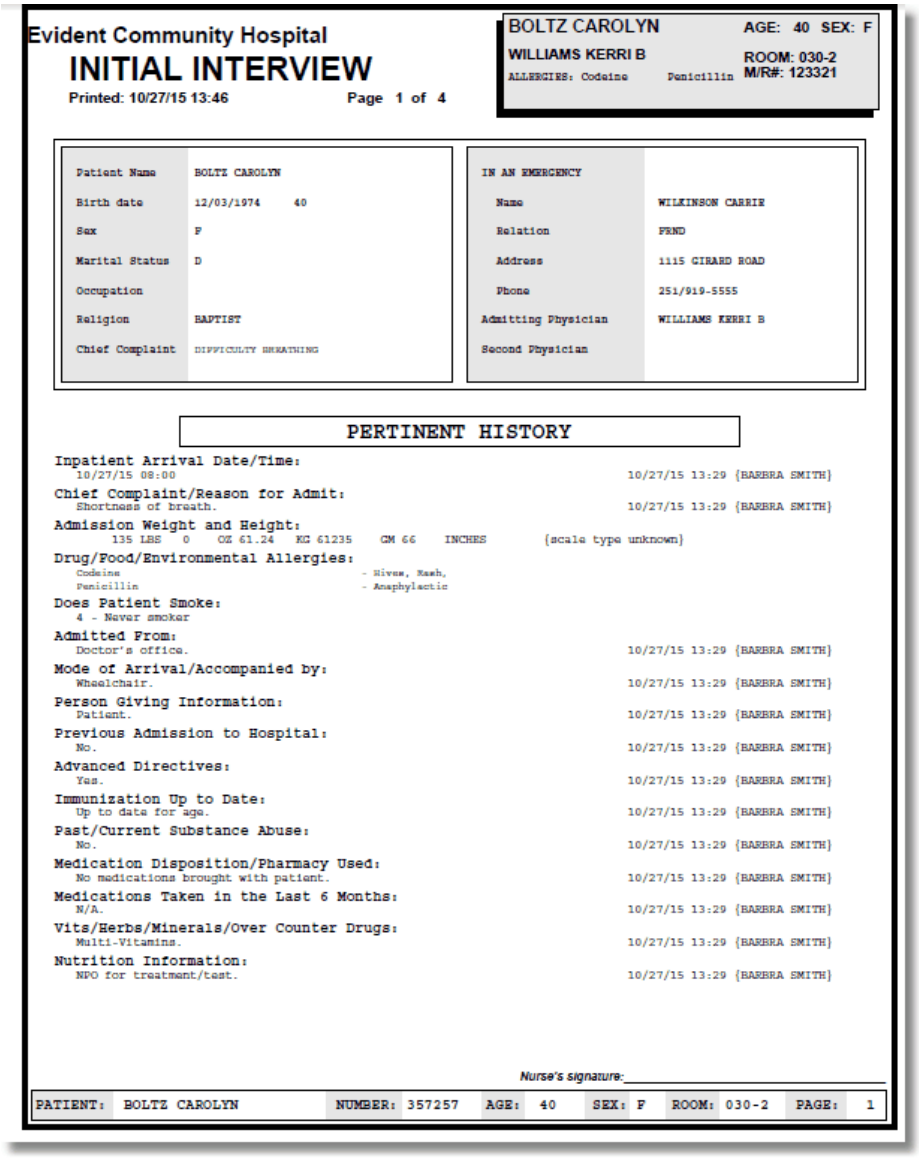
4. This option will include any stricken or amended data in the report.

21.2 Description and Usage

The Initial Interview is a document that includes information regarding the patient's demographics, pertinent history, and discharge planning. The Point of Care system allows for the ability of the patient's demographics and pertinent history to be copied from admission to another. The copying process can occur as long the patient has been registered using the same name spelling, birthday, and social security number. If POC documentation has purged to Clinical History it cannot pull forward. A message will print at the bottom of the copied version to the Initial Interview.

***NOTE**: Currently, Home Medications are copied to a new account based on the same parameters used by Copy Previous Pertinent History. If Electronic Medication Reconciliation is utilized, the medications that were continued at discharge on the previous stay will generate as Home Medications on the Initial Interview for the current stay. If the "No Home Medications" option is selected, **None** will display beneath Current Medications. The availability of documentation entered via the new Medication Reconciliation Application is not restricted by POC keep days.*

Initial Interview - Page 1



Evident Community Hospital

INITIAL INTERVIEW

Printed: 10/27/15 13:46 Page 1 of 4

BOLTZ CAROLYN AGE: 40 SEX: F
WILLIAMS KERRI B ROOM: 030-2
ALLERGIES: Codeine Penicillin M/R#: 123321

Patient Name	BOLTZ CAROLYN	IN AN EMERGENCY	
Birth date	12/03/1974 40	Name	WILKINSON CARRIE
Sex	F	Relation	FRND
Marital Status	D	Address	1115 GIRARD ROAD
Occupation		Phone	251/919-5555
Religion	BAPTIST	Admitting Physician	WILLIAMS KERRI B
Chief Complaint	DIFFICULTY BREATHING	Second Physician	

PERTINENT HISTORY

Inpatient Arrival Date/Time:
10/27/15 08:00 — 10/27/15 13:29 {BARBRA SMITH}

Chief Complaint/Reason for Admit:
Shortness of breath. — 10/27/15 13:29 {BARBRA SMITH}

Admission Weight and Height:
135 LBS 0 OZ 61.24 KG 61235 GM 66 INCHES {scale type unknown}

Drug/Food/Environmental Allergies:
Codeine - Hives, Rash,
Penicillin - Anaphylactic

Does Patient Smoke:
4 - Never smoker

Admitted From:
Doctor's office. — 10/27/15 13:29 {BARBRA SMITH}

Mode of Arrival/Accompanied by:
Wheelchair. — 10/27/15 13:29 {BARBRA SMITH}

Person Giving Information:
Patient. — 10/27/15 13:29 {BARBRA SMITH}

Previous Admission to Hospital:
No. — 10/27/15 13:29 {BARBRA SMITH}

Advanced Directives:
Yes. — 10/27/15 13:29 {BARBRA SMITH}

Immunization Up to Date:
Up to date for age. — 10/27/15 13:29 {BARBRA SMITH}

Past/Current Substance Abuse:
No. — 10/27/15 13:29 {BARBRA SMITH}

Medication Disposition/Pharmacy Used:
No medications brought with patient. — 10/27/15 13:29 {BARBRA SMITH}

Medications Taken in the Last 6 Months:
N/A. — 10/27/15 13:29 {BARBRA SMITH}

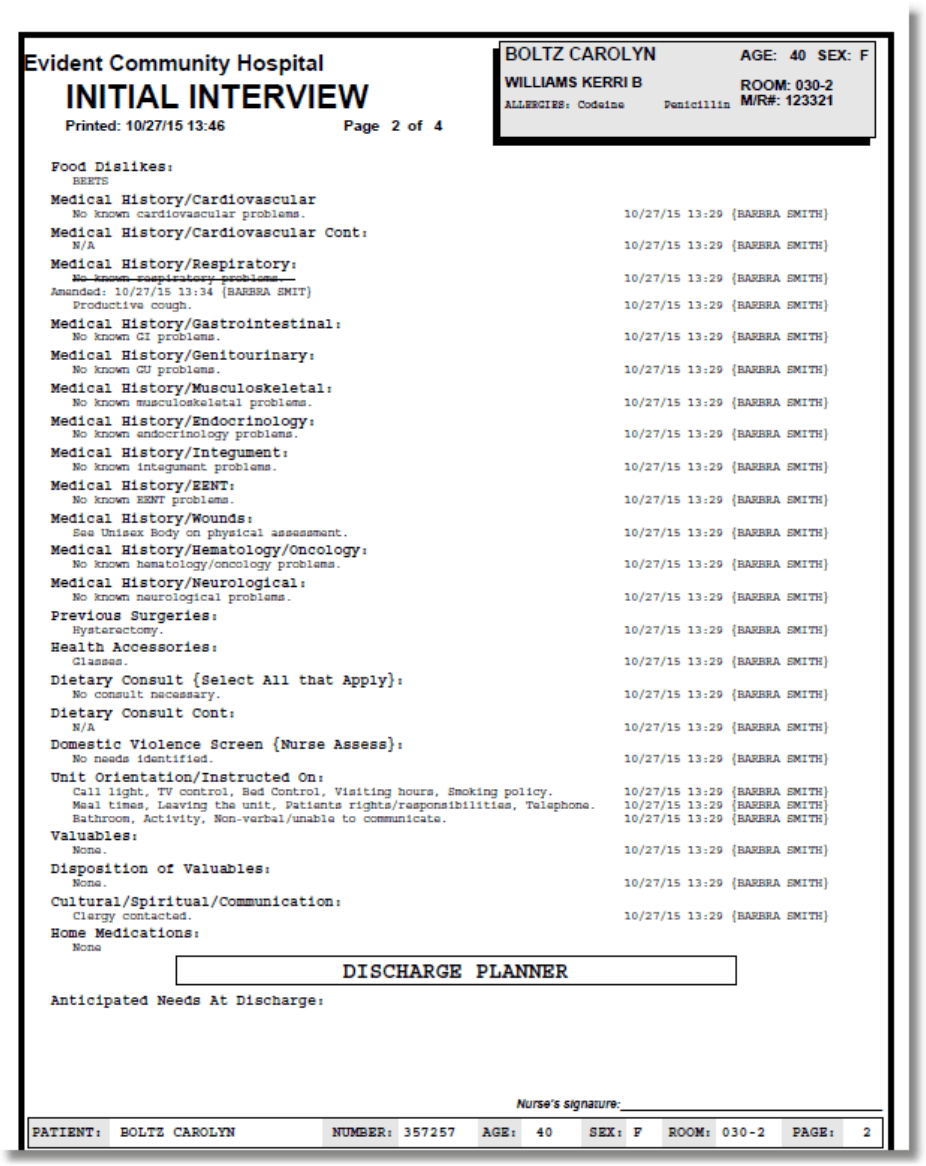
Vits/Herbs/Minerals/Over Counter Drugs:
Multi-Vitamins. — 10/27/15 13:29 {BARBRA SMITH}

Nutrition Information:
NPO for treatment/test. — 10/27/15 13:29 {BARBRA SMITH}

*Nurse's signature:*_____

PATIENT: BOLTZ CAROLYN NUMBER: 357257 AGE: 40 SEX: F ROOM: 030-2 PAGE: 1

Initial Interview - Page 2



Evident Community Hospital

INITIAL INTERVIEW

Printed: 10/27/15 13:46 Page 2 of 4

BOLTZ CAROLYN AGE: 40 SEX: F
WILLIAMS KERRI B ROOM: 030-2
ALLERGIES: Codeine Penicillin M/R#: 123321

Food Dislikes:
BEETS

Medical History/Cardiovascular
No known cardiovascular problems. 10/27/15 13:29 {BARBRA SMITH}

Medical History/Cardiovascular Cont:
N/A 10/27/15 13:29 {BARBRA SMITH}

Medical History/Respiratory:
~~No known respiratory problems.~~ 10/27/15 13:29 {BARBRA SMITH}
Amended: 10/27/15 13:34 {BARBRA SMIT}
Productive cough. 10/27/15 13:29 {BARBRA SMITH}

Medical History/Gastrointestinal:
No known GI problems. 10/27/15 13:29 {BARBRA SMITH}

Medical History/Genitourinary:
No known GU problems. 10/27/15 13:29 {BARBRA SMITH}

Medical History/Musculoskeletal:
No known musculoskalatal problems. 10/27/15 13:29 {BARBRA SMITH}

Medical History/Endocrinology:
No known endocrinology problems. 10/27/15 13:29 {BARBRA SMITH}

Medical History/Integument:
No known integument problems. 10/27/15 13:29 {BARBRA SMITH}

Medical History/EENT:
No known EENT problems. 10/27/15 13:29 {BARBRA SMITH}

Medical History/Wounds:
See Unisex Body on physical assessment. 10/27/15 13:29 {BARBRA SMITH}

Medical History/Hematology/Oncology:
No known hematology/oncology problems. 10/27/15 13:29 {BARBRA SMITH}

Medical History/Neurological:
No known neurological problems. 10/27/15 13:29 {BARBRA SMITH}

Previous Surgeries:
Hysterectomy. 10/27/15 13:29 {BARBRA SMITH}

Health Accessories:
Glasses. 10/27/15 13:29 {BARBRA SMITH}

Dietary Consult {Select All that Apply}:
No consult necessary. 10/27/15 13:29 {BARBRA SMITH}

Dietary Consult Cont:
N/A 10/27/15 13:29 {BARBRA SMITH}

Domestic Violence Screen {Nurse Assess}:
No needs identified. 10/27/15 13:29 {BARBRA SMITH}

Unit Orientation/Instructed On:
Call light, TV control, Bed Control, Visiting hours, Smoking policy. 10/27/15 13:29 {BARBRA SMITH}
Meal times, Leaving the unit, Patients rights/responsibilities, Telephone. 10/27/15 13:29 {BARBRA SMITH}
Bathroom, Activity, Non-verbal/unable to communicate. 10/27/15 13:29 {BARBRA SMITH}

Valuables:
None. 10/27/15 13:29 {BARBRA SMITH}

Disposition of Valuables:
None. 10/27/15 13:29 {BARBRA SMITH}

Cultural/Spiritual/Communication:
Clergy contacted. 10/27/15 13:29 {BARBRA SMITH}

Home Medications:
None

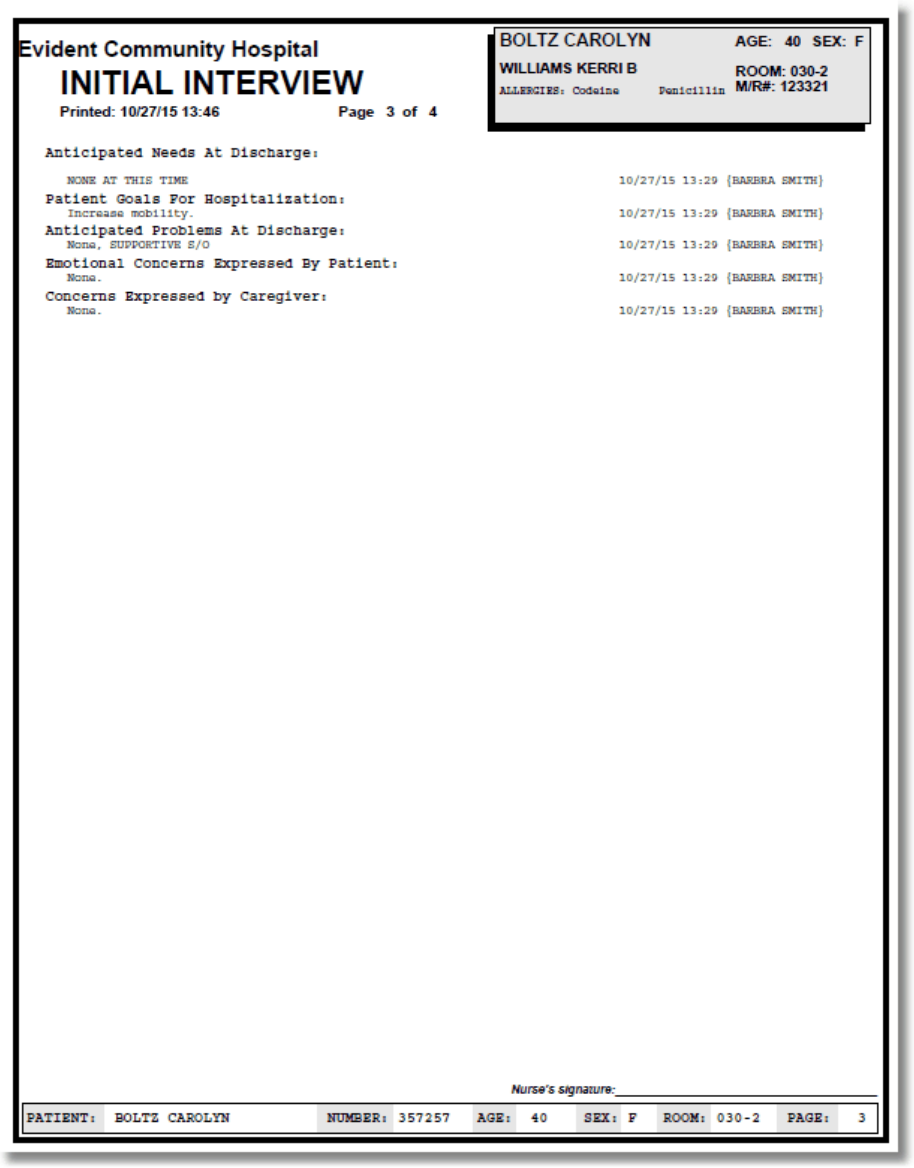
DISCHARGE PLANNER

Anticipated Needs At Discharge:

*Nurse's signature:*_____

PATIENT: BOLTZ CAROLYN NUMBER: 357257 AGE: 40 SEX: F ROOM: 030-2 PAGE: 2

Initial Interview - Page 3



Evident Community Hospital

INITIAL INTERVIEW

Printed: 10/27/15 13:46 Page 3 of 4

BOLTZ CAROLYN AGE: 40 SEX: F
WILLIAMS KERRI B ROOM: 030-2
ALLERGIES: Codeine Penicillin M/R#: 123321

Anticipated Needs At Discharge:

NONE AT THIS TIME 10/27/15 13:29 [BARBRA SMITH]

Patient Goals For Hospitalization:
Increase mobility. 10/27/15 13:29 [BARBRA SMITH]

Anticipated Problems At Discharge:
None, SUPPORTIVE S/O 10/27/15 13:29 [BARBRA SMITH]

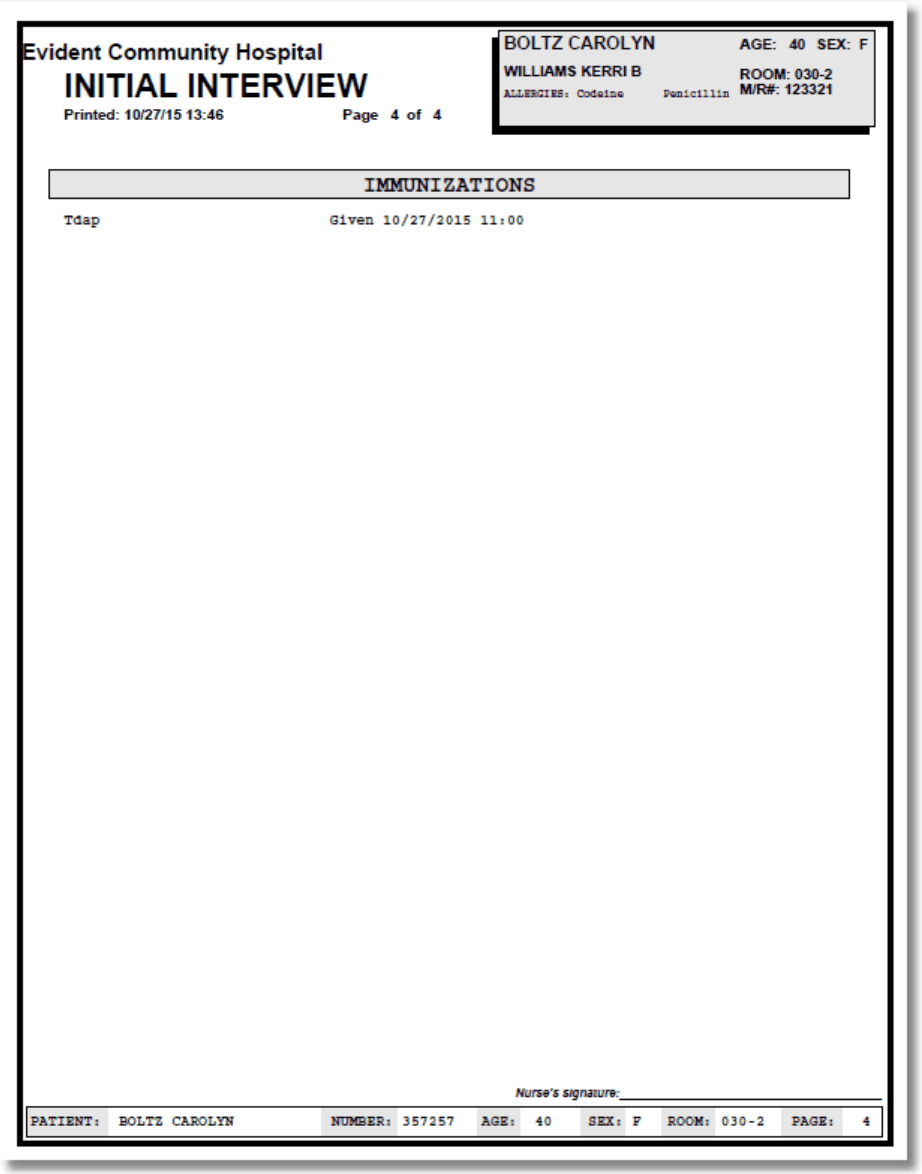
Emotional Concerns Expressed By Patient:
None. 10/27/15 13:29 [BARBRA SMITH]

Concerns Expressed by Caregiver:
None. 10/27/15 13:29 [BARBRA SMITH]

*Nurse's signature:*_____

PATIENT: BOLTZ CAROLYN NUMBER: 357257 AGE: 40 SEX: F ROOM: 030-2 PAGE: 3

Initial Interview - Pg. 4



Evident Community Hospital

INITIAL INTERVIEW

Printed: 10/27/15 13:46 Page 4 of 4

BOLTZ CAROLYN AGE: 40 SEX: F
WILLIAMS KERRI B ROOM: 030-2
ALLERGIES: Codeine Penicillin M/R#: 123321

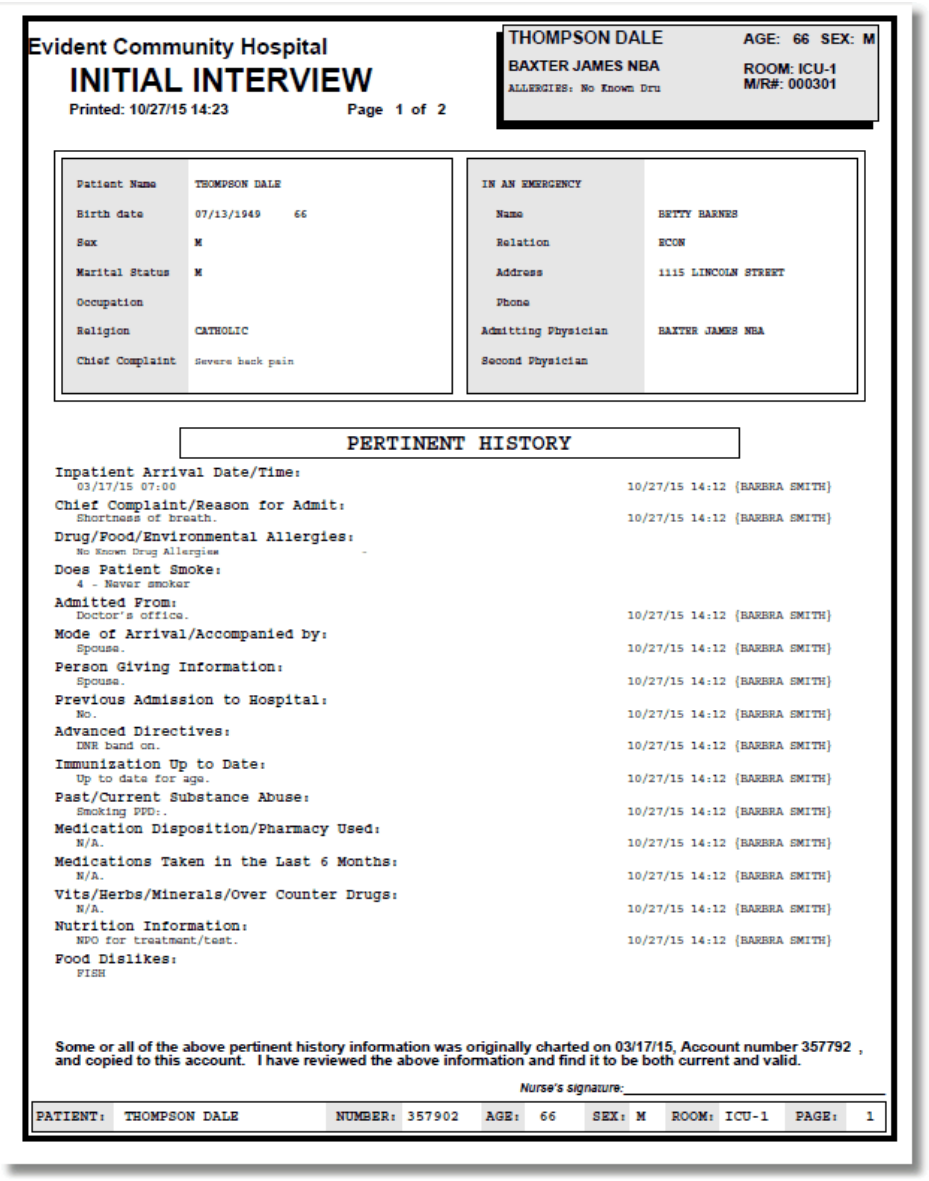
IMMUNIZATIONS

Tdap Given 10/27/2015 11:00

Nurse's signature:_____

PATIENT: BOLTZ CAROLYN NUMBER: 357257 AGE: 40 SEX: F ROOM: 030-2 PAGE: 4

Initial Interview with "Copy Previous Pertinent History" Message



Evident Community Hospital

INITIAL INTERVIEW

Printed: 10/27/15 14:23 Page 1 of 2

THOMPSON DALE AGE: 66 SEX: M
BAXTER JAMES NBA ROOM: ICU-1
ALLERGIES: No Known Dru M/R#: 000301

Patient Name	THOMPSON DALE	IN AN EMERGENCY	
Birth date	07/13/1949 66	Name	BETTY BARNES
Sex	M	Relation	SON
Marital Status	M	Address	1115 LINCOLN STREET
Occupation		Phone	
Religion	CATHOLIC	Admitting Physician	BAXTER JAMES NBA
Chief Complaint	Severe back pain	Second Physician	

PERTINENT HISTORY

Inpatient Arrival Date/Time:
03/17/15 07:00

Chief Complaint/Reason for Admit: 10/27/15 14:12 (BARBRA SMITH)
Shortness of breath.

Drug/Food/Environmental Allergies: 10/27/15 14:12 (BARBRA SMITH)
No Known Drug Allergies

Does Patient Smoke:
4 - Never smoker

Admitted From: 10/27/15 14:12 (BARBRA SMITH)
Doctor's office.

Mode of Arrival/Accompanied by: 10/27/15 14:12 (BARBRA SMITH)
Spouse.

Person Giving Information: 10/27/15 14:12 (BARBRA SMITH)
Spouse.

Previous Admission to Hospital: 10/27/15 14:12 (BARBRA SMITH)
No.

Advanced Directives: 10/27/15 14:12 (BARBRA SMITH)
DNR band on.

Immunization Up to Date: 10/27/15 14:12 (BARBRA SMITH)
Up to date for age.

Past/Current Substance Abuse: 10/27/15 14:12 (BARBRA SMITH)
Smoking PPD:.

Medication Disposition/Pharmacy Used: 10/27/15 14:12 (BARBRA SMITH)
N/A.

Medications Taken in the Last 6 Months: 10/27/15 14:12 (BARBRA SMITH)
N/A.

Vits/Herbs/Minerals/Over Counter Drugs: 10/27/15 14:12 (BARBRA SMITH)
N/A.

Nutrition Information: 10/27/15 14:12 (BARBRA SMITH)
NPO for treatment/test.

Food Dislikes:
FISH

Some or all of the above pertinent history information was originally charted on 03/17/15, Account number 357792 , and copied to this account. I have reviewed the above information and find it to be both current and valid.

*Nurse's signature:*_____

PATIENT: THOMPSON DALE NUMBER: 357902 AGE: 66 SEX: M ROOM: ICU-1 PAGE: 1

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Displays patient's name, admitting physician, age, sex, room number, medical record number, and any allergies documented through the TruBridge EHR system. In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number, and page number will appear along the bottom edge of the page.

- **Patient Information Box:**

Patient's name	Name (person to contact in an emergency)	
Birth date and age	Relation (of above person)	Sex
Address	Marital status	Phone
Occupation	Attending physician	Religion
Consulting physician	Chief Complaint	

- **Immunizations:** Lists immunizations and the dates they were received

Chapter 22 Initial Physical Assessment

The Initial Physical Assessment is a document that includes information regarding the patient's initial vital signs and assessment of body systems. It can be printed at anytime during the patient's stay, but should be primarily printed after completion on the system. If modifications are made, the report should be printed again. The nursing staff can print the report, but the nurse assigned to the patient primarily prints it or staff who make modifications to the report. Printing the Initial Physical Assessment is mandatory, unless otherwise specified by hospital policy. The report is usually a permanent part of the patient's chart.

NOTE: *The system will print the Late Entry stamp to late entries made to the Initial Physical Assessment. When user is prompted to reprint notes they must go to Printing Menu Page 2 and reprint the Initial Physical Assessment.*

22.1 How to Print

The Initial Physical Assessment may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart select the appropriate tab.
3. Select **Initial Physical Assessment Report**.

   System prompts "Include stricken/amended data?"

4. This option will include any stricken or amended data in the report.

22.2 Description and Usage

The Initial Physical Assessment is a document that includes information regarding the patient's initial vital signs and assessment of body systems.

Initial Physical Assessment - Page 1

Initial Physical Assessment – Page 1

INITIAL PHYSICAL ASSESSMENT

ANDERS NEIL
F McKENZIE LANGOWRTHY II
ALLERGIES: No Known Drs
AGE: 28
SEX: M
ROOM: 501
M/R#: 897946562

Page 1 of 2

Initial Vital Signs

Temp:	100.2	TYMPANIC	01/30/04 15:46 (JJD, RN)
Pulse:	70	BRACHIAL	01/30/04 15:46 (JJD, RN)
Resp:	16		01/30/04 15:46 (JJD, RN)
B/P:	128/68	SITTING	01/30/04 15:46 (JJD, RN)
O2 L/M:	2.5		02/04/04 08:45 (JJD, RN)
FiO2:	50		02/04/04 08:45 (JJD, RN)
O2 SAT:	97		01/30/04 15:46 (JJD, RN)
Method:	Room Air 21%		01/30/04 15:46 (JJD, RN)
Weight:	228 lbs 103.64 kg 103636.4 gm		01/30/04 15:43 (JJD, RN)

PULMONARY ASSESSMENT

Quality of respirations:
02/04/04 08:31 (JJD, RN) regular.

Auscultation (Adventitious sounds & location):
02/04/04 08:31 (JJD, RN) wheeze, Right side, clear, Left side.

Cough:
02/04/04 08:31 (JJD, RN) productive, occasional.

Sputum:
02/04/04 08:31 (JJD, RN) green, moderate.

Oxygen:
02/04/04 08:31 (JJD, RN) nasal cannula.

Nose:
02/04/04 08:31 (JJD, RN) left nare, congested, rt.nare.

Dressing:
02/04/04 08:31 (JJD, RN) dry, intact.

MUSCULOSKELETAL ASSESSMENT

Fall Precautions:
02/04/04 08:32 (JJD, RN) yes.

Walks unaided:
02/04/04 08:32 (JJD, RN) unsteady.

Walks aided by:
02/04/04 08:32 (JJD, RN) hold on assist.

Hand grasps:
02/04/04 08:32 (JJD, RN) equal, strong.

Leg strength:
02/04/04 08:32 (JJD, RN) right sided weakness.

Sensations:
02/04/04 08:32 (JJD, RN) No c/o numbness, tingling or pain.

Sprain:
02/04/04 08:32 (JJD, RN) right, ankle.

Arthritis:
02/04/04 08:32 (JJD, RN) right, knee.

Inflammation of Joints:
02/04/04 08:32 (JJD, RN) right, knee, right, ankle.

Moves all extremities:

Nurse's signature:_____ Validated by:_____

PATIENT:	ANDERS NEIL	NUMBER:	401247	AGE:	28	SEX:	M	ROOM:	501	PAGE:	1

Initial Physical Assessment - Page 2

Initial Physical Assessment – Page 2

INITIAL PHYSICAL ASSESSMENT

ANDERS NEIL
F McKENZIE LANGOWRTHY II
ALLERGIES: No Known Dru
AGE: 28
SEX: M
ROOM: 501
M/R#: 897946562

Page 2 of 3

GENITOURINARY ASSESSMENT

Basic Assessment
07/18/03 15:24 (J DOE, RN) Patient denies complaint of pain, burning, frequency, hesitancy or itching when voiding. Bladder is nondistended. Urine is clear and yellow to amber in color.

REPRODUCTIVE ASSESSMENT

Basic Assessment
07/18/03 15:24 (J DOE, RN) Patient does not express sexual dysfunction and/or inadequacy.

MUSCULOSKELETAL ASSESSMENT

Basic Assessment
07/18/03 15:24 (J DOE, RN) Peripheral pulses are palpable. Sensation intact. Pt. maintains upright posture, walks unaided maintaining balance. There is absence of joint swelling and tenderness. Normal ROM for patient. No muscle weakness. Surrounding tissue shows no evidence of inflammation.

NEUROLOGICAL ASSESSMENT

Basic Assessment
07/18/03 15:23 (J DOE, RN) Patient is awake, alert and oriented to time, place and person. Responds appropriately to verbal and non-verbal stimuli. Pupils are equally round and responsive to light.

INJURY RISK ASSESSMENT

Safety Measures:
07/18/03 15:20 (J DOE, RN) Side rails up x4.
Care Needs
07/18/03 15:20 (J DOE, RN) Comfort Addressed, ADL Addressed, Food/Fluids Offered, Room & Patient clean & dry.
Bed exit armed
07/18/03 15:20 (J DOE, RN) yes.
Call bell within reach:
07/18/03 15:20 (J DOE, RN) yes, Bed exit armed.
yes.
Arm band is on patient's wrist and labeled properly:
07/18/03 15:20 (J DOE, RN) yes.
Significant other at bedside:
07/18/03 15:20 (J DOE, RN) husband.

WOUND ASSESSMENT

Basic Assessment
07/18/03 15:25 (J DOE, RN) No wound present. Skin intact.

PAIN ASSESSMENT

Pain Scale (0-10)
07/18/03 15:24 (J DOE, RN) 5
Patient complains of:
07/18/03 15:24 (J DOE, RN) moderate pain.
RELIEVING FACTORS
07/18/03 15:24 (J DOE, RN) Relaxation techniques.
RESPONSE TO PAIN MANAGEMENT
07/18/03 15:24 (J DOE, RN) Pain controlled.
NAUSEA

Nurse's signature:_____ Validated by:_____

PATIENT:	BOLTZ CAROLYN	NUMBER:	356959	AGE:	58	SEX:	F	ROOM:	117	PAGE:	2

Initial Physical Assessment - Page 3

Initial Physical Assessment – Page 3

INITIAL PHYSICAL ASSESSMENT

ANDERS NEIL
F McKENZIE LANGOWRTHY II
ALLERGIES: No Known Dru

AGE: 28
SEX: M
ROOM: 501
M/R#: 897946562

Page 3 of 3

NAUSEA

07/18/03 15:24 (J DOE, RN) No.

PSYCHOSOCIAL ASSESSMENT

Behavior:
07/18/03 15:21 (J DOE, RN) cooperative.

Sleep habits (newly created ?)
07/18/03 15:21 (J DOE, RN) _5-6____ hrs/night.

Does Patient nap?
07/18/03 15:21 (J DOE, RN) no.

Recent changes in sleep pattern:
07/18/03 15:21 (J DOE, RN) no.

Interaction with others
07/18/03 15:21 (J DOE, RN) Other_APPROPRIATE_____.

Safety Measures
07/18/03 15:21 (J DOE, RN) Side rails up X4.

INTRAVENOUS ASSESSMENT

Basic Assessment
07/18/03 15:24 (J DOE, RN) IV intact with no redness or swelling at site. Patient denies discomfort.

Nurse's signature:_____ Validated by:_____

PATIENT:	BOLTZ CAROLYN	NUMBER:	356959	AGE:	58	SEX:	F	ROOM:	117	PAGE:	3

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Displays patient's name, admitting physician, age, sex, room number, medical record number, and any drug allergies documented through the TruBridge EHR system. In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

- **Initial Vital Signs:** Displays temperature (including site), pulse (including site), respiration, blood pressure (including posture and extremity), weight, O2, O2 L/Min, FiO2, O2 Sat, and the date, time, name and title of the person who charted the information.

- **Assessment Categories:** Each assessment will be preceded by the appropriate heading below:

▪ Metabolic/Integument	▪ Pulmonary	▪ Cardiovascular
▪ Gastrointestinal	▪ Genitourinary	▪ Reproductive
▪ Musculoskeletal	▪ Neurological	▪ Injury Risk
▪ Pain	▪ Psychosocial	▪ Intravenous
▪ Wound		

Chapter 23 M.A.R.

The MAR - Temporary is a document that includes the patient's medication administration chart for the current 24 hours, based on one of the following time periods determined by nursing administration: 0700 – 0659, 1500 – 1459 or 2300 – 2259. It can be printed at anytime during the patient's stay by the nursing staff. Printing of the MAR is optional, unless otherwise specified by hospital policy. The report is a temporary report and usually not a permanent part of the patient's chart.

23.1 How to Print

The M.A.R. may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.

2. From the Virtual Chart select the appropriate tab.

3. Select **MAR Temp**.

23.2 Description and Usage

The MAR - Temporary is a document that includes the patient's medication administration chart for the current 24 hours, based on one of the following time periods determined by nursing administration: 0700 – 0659, 1500 – 1459 or 2300 – 2259. The medications are grouped by categories (X1, Scheduled/Routine, IV orders and PRN) and display in the order in that they were entered into the system. The 24 hours display in eight-hour time periods, with the medication administration time(s) and the initials of the nurse who administered the medication appearing below, if the medication was given. (The Medication Record that is printed from the Nursing Department, Hospital Base menu-Print Reports-A or the Nursing Department, Patient Functions Screen-Z, does not include the administration time(s) and the initials of the nurse who administered the medication.)

Listed below is an explanation of each column.

- **Demographics Box (upper right-hand corner):** Displays patient's name, admitting physician, age, sex, date of birth, room number, medical record number, and any drug and food allergies documented through the TruBridge EHR system. In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number, chief complaint and page number will appear along the bottom edge of the page.

- **One-Time Orders:** All X1 medications that were ordered, scheduled, administered or discontinued during the 24 hour period covered by the report will display as well as the start and stop date, stop code and "Unverified" if the medication has not been verified.

- **One-Time Orders – Cont.:** Displays medication description, dosage, frequency, instructions, and scheduled time under the appropriate hour of the eight-hour block. The initials of the person who administered the medication or "G" and the administration time will appear under the appropriate hour of the eight-hour block. If a medication was administered using the second witness option, the system will print the second employee's initials and time of medication administration in a bold font underneath the first employee's initials and time of medication administration.

- **Scheduled / Routine Medications:** Displays all routine medications that were ordered, scheduled, administered or discontinued during the 24 hour period covered by the report. Will also display the start date, stop date if applicable, stop code if applicable and "Unverified" if the medication has not been verified, medication description, dosage, frequency, instructions, components and flow rate on piggybacks, and the scheduled time appears under the appropriate hour of the eight-hour block. The initials of the person who administered the medication or "G" and the administration time will appear under the appropriate hour of the eight-hour block. If a medication was administered using the second witness option, the system will print the second employee's initials and time of medication administration in a bold font underneath the first employee's initials and time of medication administration.

- **IV Orders:** Displays all continuous IVs that were ordered, scheduled, administered or discontinued during the 24 hour period covered by the report. Will also display the start date, stop date if applicable, stop code if applicable, and "Unverified" if the IV has not been verified, medication description, flow rate, frequency, and components. The initials of the person who administered the medication or "G" and the administration time will appear under the appropriate hour of the eight-hour block. If a medication was administered using the second witness option, the system will print the second employee's initials and time of medication administration in a bold font underneath the first employee's initials and time of medication administration. Alternating IV orders will be flagged with "***ALTERNATING IV SET 1***" or "Alt. IV Set 1***", with the number being the order number from the patient's pharmacy profile.

- **PRN Medications:** Displays all PRN medications that were ordered, administered or discontinued during the 24 hour period covered by the report. Will also display start date, stop date if applicable, stop code if applicable, and "Unverified" if the medication has not been verified, medication description, dosage, frequency, and instructions. The initials of the person who administered the medication or "G" and the administration time will appear under the appropriate hour of the eight-hour block. If a medication was administered using the second witness option, the system will print the second employee's initials and time of medication administration in a bold font underneath the first employee's initials and time of medication administration.

NOTE: *Employees' initials must be set up in the Employee Master File of the Payroll application in order for them to print as an indication that a medication was administered. If no initials are set up, the system will print a "G" (Given) under the corresponding hour of the eight-hour block.*

Chapter 24 M.A.R.- Final

The MAR-Final is a document that includes the patient's complete medication administration chart for the previous 24 hours, based on one of the following time periods determined by administration: 0700 – 0659, 1500 – 1459 or 2300 – 2259. It can be printed at anytime during the patient's stay, but should be printed automatically at a specific hour, once a day. can be printed at anytime during the patient's stay, but should be printed automatically at a specific hour, once a day. Printing the MAR-Final is optional, unless otherwise specified by hospital policy. The report is usually a permanent part of the patient's chart.

24.1 How to Print

The M.A.R. - Final may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.

2. From the Virtual Chart select the appropriate tab.

3. Select **MAR Final**.

24.2 Description and Usage

The MAR-Final is a document that includes the patient's complete medication administration chart for the previous 24 hours, based on one of the following time periods determined by administration: 0700 – 0659, 1500 – 1459 or 2300 – 2259.

- The medications are grouped by categories (X1, Scheduled/Routine, IV orders, and PRN) and display in the order in that they were entered into the system.

- The previous 24 hours display in eight-hour time periods, with the medication administration time(s), the initials of the nurse who administered the medication, and the actual time the medication was administered appearing below, if the medication was given. (The Medication Record that is printed from the Nursing Department, Hospital Base menu-Print Reports-A or the Nursing Department, Patient Functions Screen-Z, does not include the administration time(s) and the initials of the nurse who administered the medication.)

- The Point of Care MAR takes the place of the Medication Record.

Listed below is an explanation of each column.

- **Demographics Box (upper right-hand corner):** Displays patient's name, admitting physician, age, sex, date of birth, room number, medical record number, and any drug and food allergies documented through the TruBridge EHR system. In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number, chief complaint and page number will appear along the bottom edge of the page.

- **One-Time Orders:** Displays all X1 medications that were ordered, scheduled, administered or discontinued during the 24-hour period covered by the report. Will also display start and stop date, stop code and "Unverified" if the medication has not been verified, medication description, dosage, frequency, instructions, and scheduled time under the appropriate hour of the 8- hour block. The initials of the person who administered the medication or "G" and the administration time will appear under the appropriate hour of the eight-hour block. If a medication was administered using the second witness option, the system will print the second employee's initials and time of medication administration in a bold font underneath the first employee's initials and time of medication administration. If the medication has a future start date or time and is administered before the start date and time, it will pull to the MAR with an “*” to the left of the administration area.

- **Scheduled / Routine Medications:** Displays all routine medications that were ordered, scheduled, administered or discontinued during the 24-hour period covered by the report. Will also display start date, stop date if applicable, stop code if applicable and "Unverified" if the medication has not been verified, medication description, dosage, frequency, instructions, components and flow rate on piggybacks, and scheduled time under the appropriate hour of the eight - hour block. The initials of the person who administered the medication or "G" and the administration time will appear under the appropriate hour of the eight-hour block. If a medication was administered using the second witness option, the system will print the second employee's initials and time of medication administration in a bold font underneath the first employee's initials and time of medication administration. If the medication has a future start date or time and is administered before the start date and time, it will pull to the MAR with an “*” to the left of the administration area.

- **IV Orders:** Displays all continuous IVs that were ordered, scheduled, administered or discontinued during the 24-hour period covered by the report. Will also display start date, stop date if applicable, stop code if applicable, and "Unverified" if the IV has not been verified, medication description, flow rate, frequency, and components. The initials of the person who administered the medication or "G" and the administration time will appear under the appropriate hour of the eight-hour block. If a medication was administered using the second witness option, the system will print the second employee's initials and time of medication administration in a bold font underneath the first employee's initials and time of medication administration. If the medication has a future start date or time and is administered before the start date and time, it will pull to the MAR with an “*” to the left of the administration area. Alternating IV orders will be flagged with "***ALTERNATING IV SET 1***" or "Alt. IV Set 1***", with the number being the order number from the patient's pharmacy profile.

- **PRN Medications:** Displays all routine medications that were ordered, scheduled, administered or discontinued during the 24 hour period covered by the report. Will also display order number, start date, stop date if applicable, stop code if applicable and "Unverified" if the medication has not been verified, medication description, dosage, PRN frequency, instructions, and the components and flow rate on piggybacks. The time of the administration and the initials of the person who administered the medication will appear under the appropriate column. If a medication was administered using the second witness option, the system will print the second employee's initials and time of medication administration in a bold font underneath the first employee's initials and time of medication administration.

***NOTE**: If the medication has a future start date or time and is administered before the start date and time, it will pull to the MAR with an “*” to the left of the administration area.*

NOTE: *Employees' initials must be set up in the Employee Master File of the Payroll application in order for them to print as an indication that a medication was administered. If no initials are set up, the system will print a "G" (Given) under the corresponding hour of the eight-hour block.*

Chapter 25 Medication Reconciliation Report

The Medication Reconciliation Report can be used to track a patient's medications from admit to discharge or transfer to another care giver or facility. Printing the Medication Reconciliation Report is optional, unless otherwise specified by hospital policy. Depending on its usage, the report may or may not be a permanent part of the patients chart. This is based by your hospital's policy.

25.1 How to Print

The Medication Reconciliation Report may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.

2. From the Virtual Chart select the appropriate tab.

3. Select **Med-Reconciliation Report**.

   System prompts "Medication Reconciliation Report Options"
   - Reasons
   - Additional Medications
   - Physician's Discontinue Option
   - Physician's Discontinue option for Home Meds

   If **Reasons** is selected:

   A. A reason line will be added to the report under each medication.

   If **Additional Medications** is selected:

   A. Lines to write in additional medications will be added to the bottom of the report.

   If **Physician's Discontinue Option** is selected:

   A. A physician's discontinue box will be added to the report next to the existing continue option.

   If **Physician's Continue/Discontinue option for Home Meds** is selected:

   A. Continue/Discontinue options will be added for all home meds on the report.

4. Enter the report options desired and select **OK**.

25.2 Description and Usage

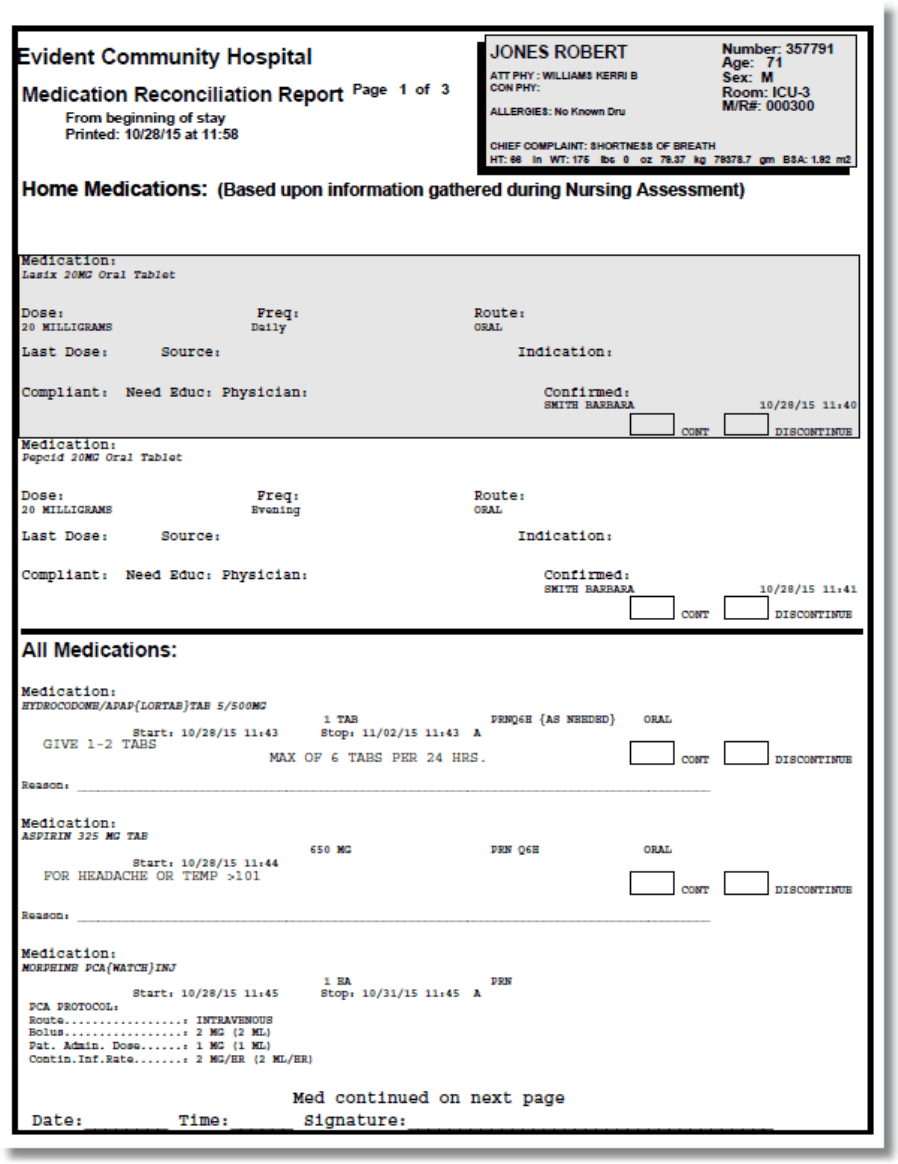
There are two options when using this report. The two options are active meds and all meds. This report can be used to track a patient's medications from admit to discharge or transfer to another care giver or facility. If Electronic Medication Reconciliation is utilized, medications will generate on this report based on documentation entered via the new Medication Reconciliation Application.

- **Active Medications Section Includes**
  - Home Medications
  - All Current Medications
  - Options available are to Continue medications, Discontinue medications, or Add Additional medications
  - Tracks the patient's active medications until discharged or transfer to another caregiver or facility

- **All Medications Section Includes**
  - Home Medications
  - All Medications
  - Options available are to Continue medications, Discontinue medications, or Add Additional meds
  - Tracks the patient's medications upon admission until discharge or transfer to another caregiver or facility

***NOTE**: If the "No Home Medications" option is selected via Medication Reconciliation, Home Medications will display as **None**.*

Medication Reconciliation Report



Evident Community Hospital

Medication Reconciliation Report Page 1 of 3

From beginning of stay
Printed: 10/28/15 at 11:58

JONES ROBERT
ATT PHY : WILLIAMS KERRI B
CON PHY:
ALLERGIES: No Known Dru
CHIEF COMPLAINT: SHORTNESS OF BREATH
HT: 66 in WT: 175 lbs 0 oz 79.37 kg 79378.7 gm BSA: 1.92 m2

Number: 357791
Age: 71
Sex: M
Room: ICU-3
M/R#: 000300

Home Medications: (Based upon information gathered during Nursing Assessment)

Medication:
Lasix 20MG Oral Tablet

Dose: 20 MILLIGRAMS
Freq: Daily
Route: ORAL

Last Dose: Source: Indication:

Compliant: Need Educ: Physician:
Confirmed: SMITH BARBARA 10/28/15 11:40

CONT DISCONTINUE

Medication:
Pepcid 20MG Oral Tablet

Dose: 20 MILLIGRAMS
Freq: Evening
Route: ORAL

Last Dose: Source: Indication:

Compliant: Need Educ: Physician:
Confirmed: SMITH BARBARA 10/28/15 11:41

CONT DISCONTINUE

All Medications:

Medication:
HYDROCODONE/APAP(LORTAB)TAB 5/500MG
1 TAB PRNQ6H (AS NEEDED) ORAL
Start: 10/28/15 11:43 Stop: 11/02/15 11:43 A
GIVE 1-2 TABS
MAX OF 6 TABS PER 24 HRS.

CONT DISCONTINUE

Reason: _____

Medication:
ASPIRIN 325 MG TAB
650 MG PRN Q6H ORAL
Start: 10/28/15 11:44
FOR HEADACHE OR TEMP >101

CONT DISCONTINUE

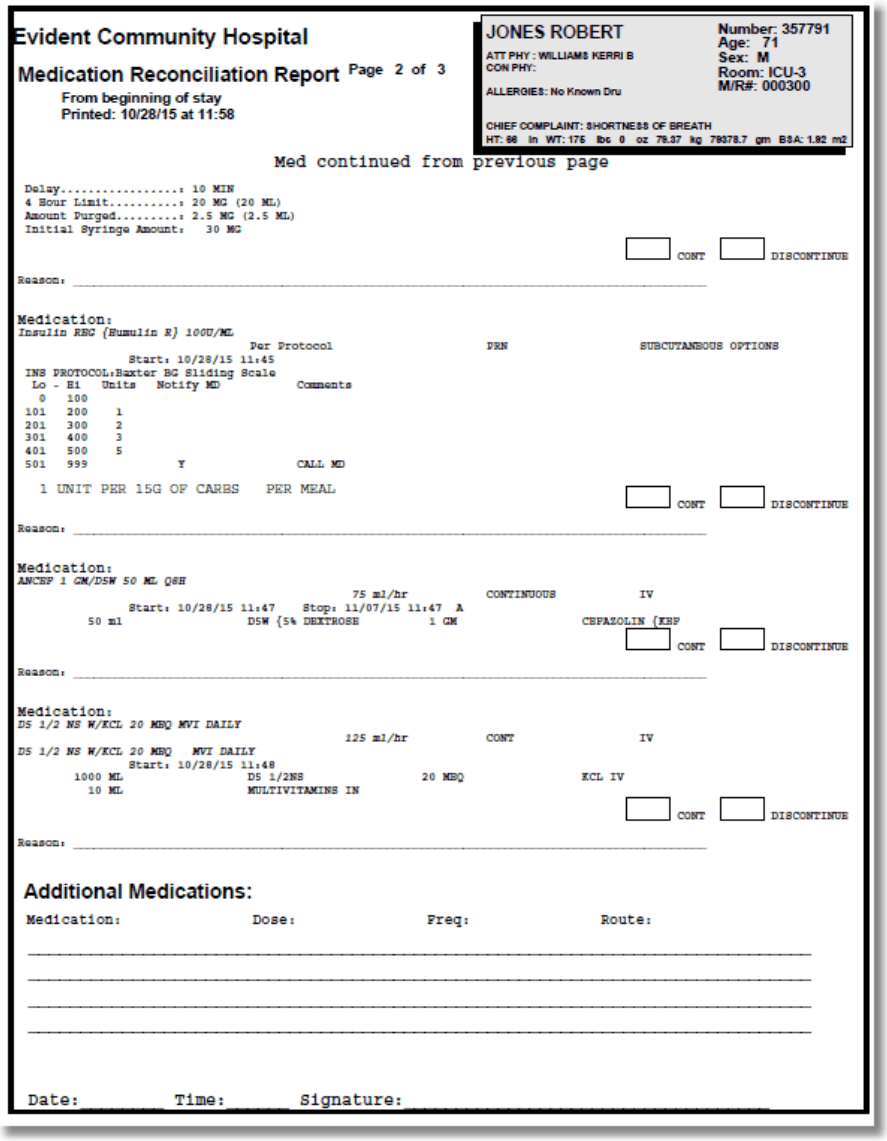
Reason: _____

Medication:
MORPHINE PCA(WATCH)INJ
1 EA PRN
Start: 10/28/15 11:45 Stop: 10/31/15 11:45 A
PCA PROTOCOL:
Route.....: INTRAVENOUS
Bolus.....: 2 MG (2 ML)
Pat. Admin. Dose.....: 1 MG (1 ML)
Contin.Inf.Rate.....: 2 MG/HR (2 ML/HR)

Med continued on next page

Date: _____ Time: _____ Signature: _____

Medication Reconciliation Report - Page 2



Evident Community Hospital

Medication Reconciliation Report Page 2 of 3

From beginning of stay
Printed: 10/28/15 at 11:58

JONES ROBERT
ATT PHY : WILLIAMS KERRI B
CON PHY:
ALLERGIES: No Known Dru
Number: 357791
Age: 71
Sex: M
Room: ICU-3
M/R#: 000300
CHIEF COMPLAINT: SHORTNESS OF BREATH
HT: 68 in WT: 175 lbs 0 oz 79.37 kg 79378.7 gm BSA: 1.92 m2

Med continued from previous page

Delay.....: 10 MIN
4 Hour Limit.....: 20 MG (20 ML)
Amount Purged.....: 2.5 MG (2.5 ML)
Initial Syringe Amount: 30 MG

CONT DISCONTINUE

Reason: _____

Medication:
Insulin REG (Humulin R) 100U/ML
Per Protocol PRN SUBCUTANEOUS OPTIONS
Start: 10/28/15 11:45
INS PROTOCOL:Baxter BG Sliding Scale

Lo - Hi	Units	Notify MD	Comments
0 100			
101 200	1		
201 300	2		
301 400	3		
401 500	5		
501 999		Y	CALL MD

1 UNIT PER 15G OF CARBS PER MEAL

CONT DISCONTINUE

Reason: _____

Medication:
ANCEF 1 GM/D5W 50 ML Q8H
75 ml/hr CONTINUOUS IV
Start: 10/28/15 11:47 Stop: 11/07/15 11:47 A
50 ml D5W (5% DEXTROSE 1 GM CEFAZOLIN (KEF

CONT DISCONTINUE

Reason: _____

Medication:
D5 1/2 NS W/KCL 20 MEQ MVI DAILY
125 ml/hr CONT IV
D5 1/2 NS W/KCL 20 MEQ MVI DAILY
Start: 10/28/15 11:48
1000 ML D5 1/2NS 20 MEQ KCL IV
10 ML MULTIVITAMINS IN

CONT DISCONTINUE

Reason: _____

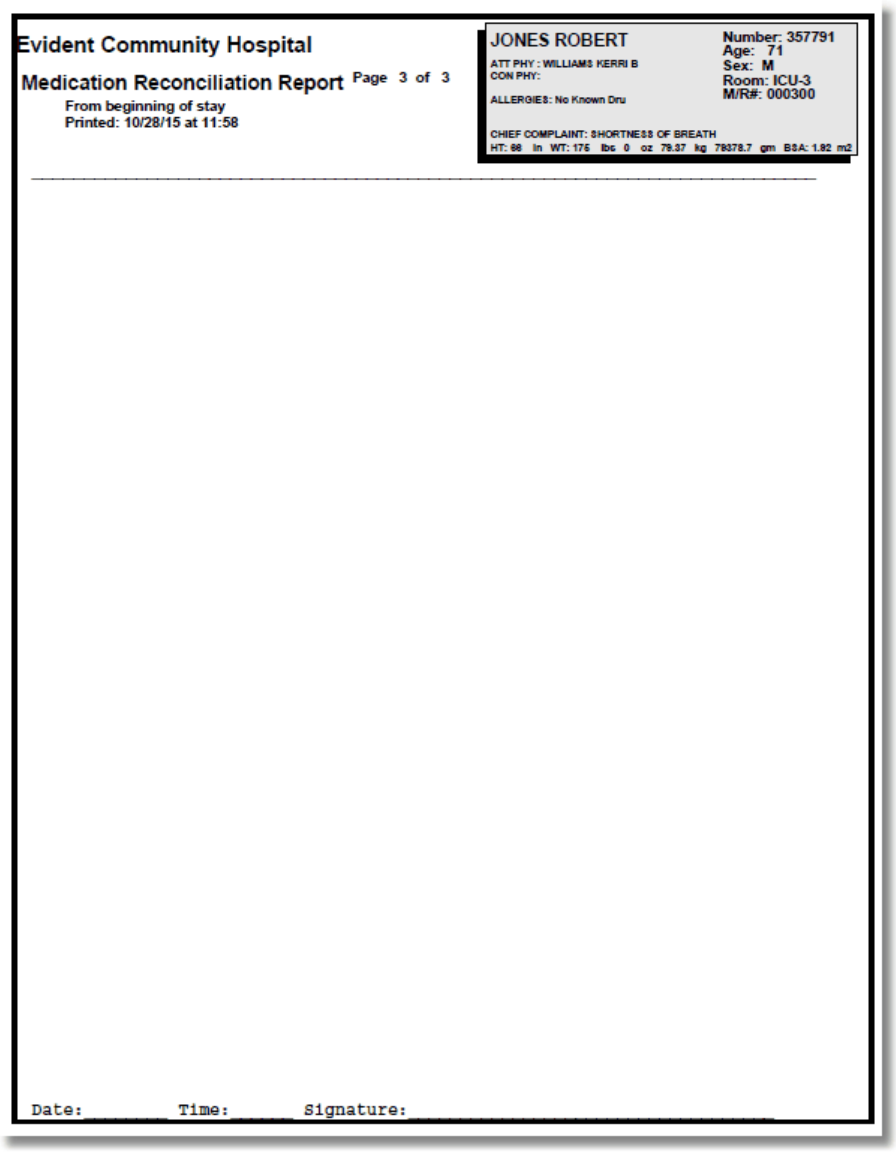
Additional Medications:

Medication: Dose: Freq: Route:

_____
_____
_____
_____

Date: _____ Time: _____ Signature: _____

Medication Reconciliation Report - Page 3



Evident Community Hospital

Medication Reconciliation Report Page 3 of 3

From beginning of stay
Printed: 10/28/15 at 11:58

JONES ROBERT
ATT PHY : WILLIAMS KERRI B
CON PHY:
ALLERGIES: No Known Dru
Number: 357791
Age: 71
Sex: M
Room: ICU-3
M/R#: 000300
CHIEF COMPLAINT: SHORTNESS OF BREATH
HT: 68 in WT: 175 lbs 0 oz 79.37 kg 79378.7 gm BSA: 1.82 m2

Date:_____ Time:_____ Signature:_____

Listed below is an explanation of each column.

- **Patient Information:** Displays patient's name, room number, age, sex, admitting physician, consulting physician, chief complaint, and any drug allergies documented through the TruBridge EHR system.

- **Medication Information:** Displays medication description, dosage, frequency, route, instructions, start/stop information including the stop codes, flow rate and components on IV piggybacks, PCA medications and protocol, the diabetic record medication and sliding scale. It also includes the option to continue or discontinue the medication as well as the option to add additional medication.

- **Demographics Box (located upper right-hand corner):** Displays patient's name, admitting physician, age, sex, room number, medical records number, and any drug allergies documented through the TruBridge EHR system. A single line containing the patient's name, account number, age, sex, room number, and page number will appear along the bottom edge of the page.

NOTE: *"Med continued on the next page" will print at the bottom of the page if information continues to the next page. "Med is continued from previous page" will print at the top of the subsequent page.*

Chapter 26 Medication Record

The Medication Record is a document that includes all ordered medications for an individual patient. It can be printed at anytime during the patient's stay by the nursing staff. Printing the Medication Record is optional, unless otherwise specified by hospital policy. The report is usually not a permanent part of the patient's chart and can be discarded after use.

26.1 How to Print

The Medication Record may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart select the appropriate tab.
3. Select **Medication Record**.

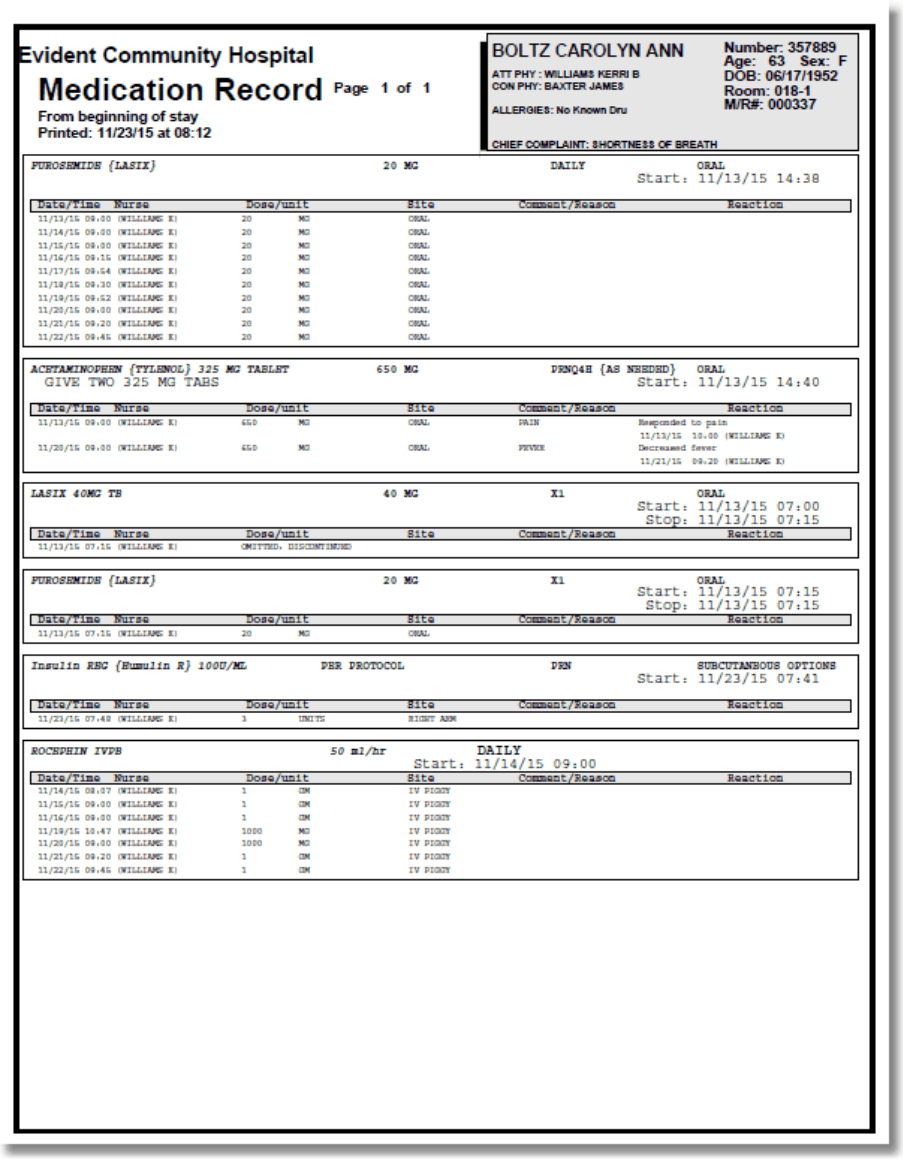
   System prompts, "Select Medication Record print dates."
4. Enter the dates that the reports is needed.
5. Select **Print**.

   System prompts "Do you want to include Administration Record?"
6. Selecting this option will include the administration record to the Medication Record.

26.2 Description and Usage

The Medication Record is a document that includes all ordered medications for an individual patient.

Medication Record



Evident Community Hospital

Medication Record Page 1 of 1

From beginning of stay
Printed: 11/23/15 at 08:12

BOLTZ CAROLYN ANN
ATT PHY : WILLIAMS KERRI B
CON PHY: BAXTER JAMES
ALLERGIES: No Known Dru
CHIEF COMPLAINT: SHORTNESS OF BREATH

Number: 357889
Age: 63 Sex: F
DOB: 06/17/1952
Room: 018-1
M/R#: 000337

FUROSEMIDE (LASIX) 20 MG DAILY ORAL
Start: 11/13/15 14:38

Date/Time	Nurse	Dose/unit		Site	Comment/Reason	Reaction
11/13/15 09.00	(WILLIAMS K)	20	MG	ORAL		
11/14/15 09.00	(WILLIAMS K)	20	MG	ORAL		
11/15/15 09.00	(WILLIAMS K)	20	MG	ORAL		
11/16/15 09.15	(WILLIAMS K)	20	MG	ORAL		
11/17/15 09.54	(WILLIAMS K)	20	MG	ORAL		
11/18/15 09.30	(WILLIAMS K)	20	MG	ORAL		
11/19/15 09.52	(WILLIAMS K)	20	MG	ORAL		
11/20/15 09.00	(WILLIAMS K)	20	MG	ORAL		
11/21/15 09.20	(WILLIAMS K)	20	MG	ORAL		
11/22/15 09.45	(WILLIAMS K)	20	MG	ORAL		

ACETAMINOPHEN (TYLENOL) 325 MG TABLET 650 MG PRNQ4H (AS NEEDED) ORAL
GIVE TWO 325 MG TABS
Start: 11/13/15 14:40

Date/Time	Nurse	Dose/unit		Site	Comment/Reason	Reaction
11/13/15 09.00	(WILLIAMS K)	650	MG	ORAL	PAIN	Responded to pain 11/13/15 10.00 (WILLIAMS K)
11/20/15 09.00	(WILLIAMS K)	650	MG	ORAL	FEVER	Decreased fever 11/21/15 09.20 (WILLIAMS K)

LASIX 40MG TB 40 MG X1 ORAL
Start: 11/13/15 07:00
Stop: 11/13/15 07:15

Date/Time	Nurse	Dose/unit	Site	Comment/Reason	Reaction
11/13/15 07.15	(WILLIAMS K)	OMITTED, DISCONTINUED			

FUROSEMIDE (LASIX) 20 MG X1 ORAL
Start: 11/13/15 07:15
Stop: 11/13/15 07:15

Date/Time	Nurse	Dose/unit		Site	Comment/Reason	Reaction
11/13/15 07.15	(WILLIAMS K)	20	MG	ORAL		

Insulin REG (Humulin R) 100U/ML PER PROTOCOL PRN SUBCUTANEOUS OPTIONS
Start: 11/23/15 07:41

Date/Time	Nurse	Dose/unit		Site	Comment/Reason	Reaction
11/23/15 07.48	(WILLIAMS K)	3	UNITS	RIGHT ARM		

ROCEPHIN IVPB 50 ml/hr DAILY
Start: 11/14/15 09:00

Date/Time	Nurse	Dose/unit		Site	Comment/Reason	Reaction
11/14/15 08.57	(WILLIAMS K)	1	GM	IV PIGGY		
11/15/15 09.00	(WILLIAMS K)	1	GM	IV PIGGY		
11/16/15 09.00	(WILLIAMS K)	1	GM	IV PIGGY		
11/19/15 10.47	(WILLIAMS K)	1000	MG	IV PIGGY		
11/20/15 09.00	(WILLIAMS K)	1000	MG	IV PIGGY		
11/21/15 09.20	(WILLIAMS K)	1	GM	IV PIGGY		
11/22/15 09.45	(WILLIAMS K)	1	GM	IV PIGGY		

Listed below is an explanation of each column.

- **Patient Information:** Displays patient's name, room number, age, sex, admitting physician, chief complaint, and any drug allergies documented through the TruBridge EHR system.
- **Medication Information:** Displays medication description, dosage, frequency, route, instructions, flow rate and components on IV piggybacks and will also include check boxes to either continue or discontinue the medication.
- **Omission Information:** Displays date, time, and reason medication was omitted.
- **Administration Record:** Displays date/time, nurse, dose/unit, site, and comments/reason.

NOTE: *If a medication was administered using the second witness option, the system will print the second employee's initials and time of medication administration in a bold font underneath the first employee's initials and time of medication administration.*

Chapter 27 Multidisciplinary Reports

27.1 Overview

The Multidisciplinary application allows the capability of printing reports that contain only documentation specific to a particular discipline. Access to chart as a discipline other than Nursing is determined by Employee Security. Four reports are currently available: Patient Progress Notes, Activities, Initial Interview and Initial Physical Assessment.

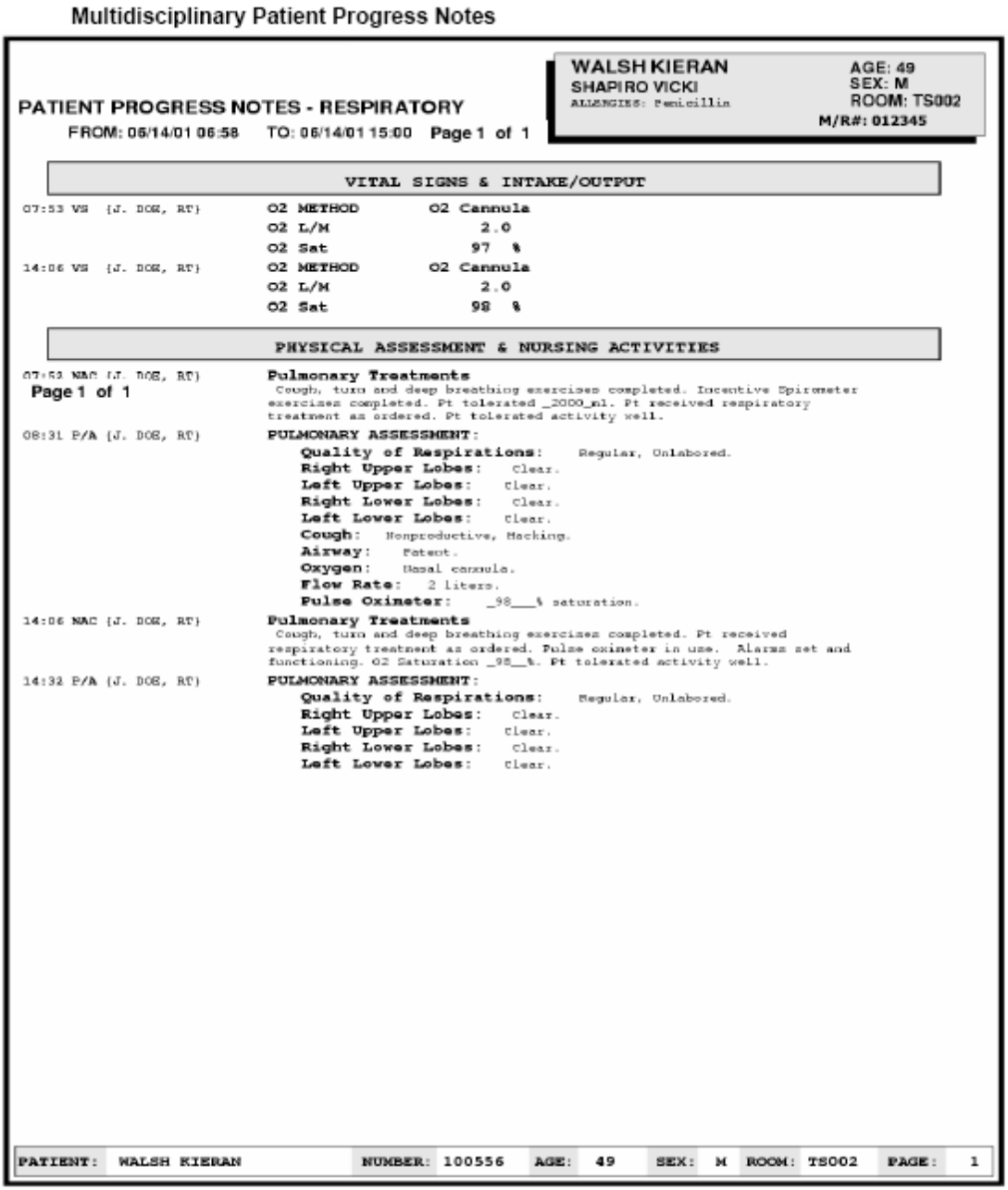
27.2 Patient Progress Notes

The Multidisciplinary Patient Progress Notes is a document that includes information from most POC applications charted during a given time frame. It can be printed at anytime during the patient's stay, but should be printed at the end of each shift and at patient discharge. The Multidisciplinary staff can print the report; however, the nurse assigned to the patient can also print the Patient Progress Notes with multidisciplinary documentation included. Printing the Multidisciplinary Patient Progress Notes is mandatory, unless otherwise specified by hospital policy. The report is usually a permanent part of the patient's chart.

Description and Usage

The Multidisciplinary Patient Progress Notes is a document that includes information from most POC applications charted during a given time frame. The Initial Interview and Initial Physical Assessment are not included in the Multidisciplinary Patient Progress Notes. Documentation from the nursing staff will print to the report if selected.

Patient Progress Notes



Multidisciplinary Patient Progress Notes

PATIENT PROGRESS NOTES - RESPIRATORY

FROM: 06/14/01 06:58 TO: 06/14/01 15:00 Page 1 of 1

WALSH KIERAN
SHAPIRO VICKI
ALLERGIES: Penicillin

AGE: 49
SEX: M
ROOM: TS002
M/R#: 012345

VITAL SIGNS & INTAKE/OUTPUT

07:53 VS (J. DOE, RT) O2 METHOD O2 Cannula
O2 L/M 2.0
O2 Sat 97 %
14:06 VS (J. DOE, RT) O2 METHOD O2 Cannula
O2 L/M 2.0
O2 Sat 98 %

PHYSICAL ASSESSMENT & NURSING ACTIVITIES

07:53 NAC (J. DOE, RT) Pulmonary Treatments
Page 1 of 1
Cough, turn and deep breathing exercises completed. Incentive Spirometer exercises completed. Pt tolerated _2000_ml. Pt received respiratory treatment as ordered. Pt tolerated activity well.

08:31 P/A (J. DOE, RT) PULMONARY ASSESSMENT:
Quality of Respirations: Regular, Unlabored.
Right Upper Lobes: Clear.
Left Upper Lobes: Clear.
Right Lower Lobes: Clear.
Left Lower Lobes: Clear.
Cough: Nonproductive, Hacking.
Airway: Patent.
Oxygen: Nasal cannula.
Flow Rate: 2 liters.
Pulse Oximeter: _98___% saturation.

14:06 NAC (J. DOE, RT) Pulmonary Treatments
Cough, turn and deep breathing exercises completed. Pt received respiratory treatment as ordered. Pulse oximeter in use. Alarms set and functioning. O2 Saturation _98__%. Pt tolerated activity well.

14:32 P/A (J. DOE, RT) PULMONARY ASSESSMENT:
Quality of Respirations: Regular, Unlabored.
Right Upper Lobes: Clear.
Left Upper Lobes: Clear.
Right Lower Lobes: Clear.
Left Lower Lobes: Clear.

PATIENT: WALSH KIERAN NUMBER: 100556 AGE: 49 SEX: M ROOM: TS002 PAGE: 1

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Displays patient's name, admitting physician, age, sex, room number, and any drug allergies documented through the TruBridge EHR system. In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number, and page number will appear along the bottom edge of the page.

- **Entries:** Each entry will fall under the appropriate application heading. The heading will be highlighted with bold text and preceded by the following:
  - Time the entry was charted
  - The name and title of the individual who entered the information
  - Two to three character code indicating the application in which the entry was charted

- **Application codes and descriptions:** Displays the following:

(P/A)-Physical Assessment	(NSS)-Shift Summary	(PCA)-PCA Medications
(MED)-Pharmacy	(EDU)-Education	(VS)-Vital Signs
(NO)-Nursing Order	(BSU)-Diabetic Record	(ORD)-Ancillary Orders
(F/S)-Floor Stock	(NAC)-Nursing Activities	(PL)-Problem List

- **Signature Line:** An optional signature line is provided at the bottom of this report. A switch located in the POC control record controls whether or not the signature line displays on the Multidisciplinary Patient Progress Notes.

- **Progress Note Format:** There are a choice of three formats set up in the chart cart control record. Format A will display vertically with entries in chronological order. Format B will display vertically grouped information based on what user has set up in the control record, in chronological order. Format C will display horizontally with entries in chronological order or in groups

27.3 Activities

The Activities report is a document that includes completed activities for the patient. The report can be printed to reflect all activities charted with in a specific shift, multiple shifts or from the beginning of stay. It can be printed at anytime during the patient’s stay by the nursing staff. Printing the Activities report is optional, unless otherwise specified by hospital policy. The report is usually not a permanent part of the patient's chart.

Description and Usage

The Activities report is a document that includes completed activities for the patient. The report can be printed to reflect all activities charted with in a specific shift, multiple shifts or from the beginning of stay.

Activities

Multidisciplinary Activities Report

WALSH KIERAN
SHAPIRO VICKI
ALLERGIES: Bactrim Penicillin
AGE: 49
SEX: M
ROOM: TS002
M/R#: 012345

ACTIVITIES

From beginning of stay TO: 03/21/00 16:45 Page 1 of 1

RESPIRATORY THERAPY

03/20/00

08:05 {JD, RT} **RESPIRATORY THERAPY**
Cough, turn and deep breathing exercises completed. Incentive Spirometer exercises completed. Pt tolerated _1500_mL. Treatment given by RT Pt tolerated tx well. O2 {NC} at _2__L/min.

12:01 {JD, RT} **RESPIRATORY THERAPY**
Cough, turn and deep breathing exercises completed. Pt refused treatment. O2 {NC} at _2__L/min.

16:25 {JD, RT} **RESPIRATORY THERAPY**
Cough, turn and deep breathing exercises completed. Nasopharyngeal suctioning completed to clear airway. Pt tolerated tx well. O2 {NC} at _2__L/min.

03/21/00

08:11 {JD, RT} **RESPIRATORY THERAPY**
Cough, turn and deep breathing exercises completed. Incentive Spirometer exercises completed. Pt tolerated _2000_mL. Treatment given by RT Pt tolerated tx well.

12:14 {JD, RT} **RESPIRATORY THERAPY**
Incentive Spirometer exercises completed. Pt tolerated _2000_mL. Treatment given by RT Pt tolerated tx well.

16:10 {JD, RT} **RESPIRATORY THERAPY**
Cough, turn and deep breathing exercises completed. Incentive Spirometer exercises completed. Pt tolerated _2000_mL. Treatment given by RT Pt tolerated tx well. ABG's obtained.

PATIENT:	WALSH KIERAN	NUMBER:	100989	AGE:	49	SEX:	M	ROOM:	TS002	PAGE:	1

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Displays patient's name, admitting physician, age, sex, room number, and any drug allergies documented through the TruBridge EHR system. In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number, and page number will appear along the bottom edge of the page.

27.4 Initial Interview

The Initial Interview is a document that includes information regarding the patient’s demographics, pertinent history, and discharge planning. It can be printed at anytime during the patient’s stay, but should be primarily printed after completion on the system. If modifications are made, the report should be printed again. The nursing staff can print the report, but the nurse assigned to the patient primarily prints it or staff who make modifications to the report. Printing the Initial Interview is mandatory, unless otherwise specified by hospital policy. The report is usually a permanent part of the patient's chart.

Description and Usage

The Initial Interview is a document that includes information regarding the patient’s demographics, pertinent history, and discharge planning.

Initial Interview

Initial Interview – Multidisciplinary – Page 1

INITIAL INTERVIEW

AS OF 03/21/00 09:36 Page 1 of 2

PHYSICAL THERAPY

WALSH KIERAN AGE: 49
SHAPIRO VICKI SEX: M
ALLERGIES: Bactrim Penicillin ROOM: TS002
M/R#: 012345

Patient Name	WALSH KIERAN	IN AN EMERGENCY	
Birth date	06/03/1950 49	Name	MARY WALSH
Sex	M	Relation	SPOUSE
Marital Status	M	Address	1600 LINCOLN AVE.
Occupation	MACHINIST	Phone	125/365-9874
Religion	BAPTIST	Attending Physician	SHAPIRO VICKI
Admit. Diag.	ORIF LT KNEE	Consulting Physician	

DIAGNOSIS: 03/21/00 09:25 [DOE JOHN, PT]
ORIF Left Knee

PRECAUTIONS: 03/21/00 09:25 [DOE JOHN, PT]
Risk of falls.

PREVIOUS HISTORY: 03/21/00 09:25 [DOE JOHN, PT]
CVA, Diabetes.

SOCIAL FUNCTION HISTORY: 03/21/00 09:25 [DOE JOHN, PT]
Married, spouse to provide assistance.

Number of steps at home 03/21/00 09:25 [DOE JOHN, PT]
10-12.

EQUIPMENT USED PRIOR TO HOSPITALIZATION: 03/21/00 09:25 [DOE JOHN, PT]
Single cane.

MENTAL STATUS: 03/21/00 09:25 [DOE JOHN, PT]
Alert and oriented X 3.

SKIN/SOFT TISSUE: 03/21/00 09:25 [DOE JOHN, PT]
Incision w/Light drainage, Incision covered, Multiple ecchymosis.

UPPER EXTREMITY ROM: 03/21/00 09:25 [DOE JOHN, PT]
Active and passive WNL.

LOWER EXTREMITY ROM: 03/21/00 09:25 [DOE JOHN, PT]
LLE, No active ROM; PROM is WFL.

UPPER EXTREMITY STRENGTH: 03/21/00 09:25 [DOE JOHN, PT]
Within normal limits bilaterally.

LOWER EXTREMITY STRENGTH: 03/21/00 09:25 [DOE JOHN, PT]
Knees limited as follows:, LLE.

SITTING BALANCE: 03/21/00 09:25 [DOE JOHN, PT]
Good.

STANDING BALANCE: 03/21/00 09:25 [DOE JOHN, PT]
Fair.

BED MOBILITY: 03/21/00 09:25 [DOE JOHN, PT]
Independant.

TRANSFERS: 03/21/00 09:25 [DOE JOHN, PT]
Independent.

SITTING TO SUPINE: 03/21/00 09:25 [DOE JOHN, PT]
Independent.

SUPINE TO SIT: 03/21/00 09:25 [DOE JOHN, PT]
Independent.

Nurse's signature: _____

PATIENT: WALSH KIERAN NUMBER: 100989 AGE: 49 SEX: M ROOM: TS002 PAGE: 1

Multidisciplinary Initial Interview – Page 2

WALSH KIERAN
SHAPIRO VICKI
ALLERGIES: Bactrim Penicillin
AGE: 49
SEX: M
ROOM: TS002
M/R#: 012345

INITIAL INTERVIEW

AS OF 03/21/00 09:36 Page 2 of 2

PHYSICAL THERAPY

ROLLING:
Independent. 03/21/00 09:25 [DOE JOHN, PT]

GAIT ASSISTANCE:
Minimal assistance. 03/21/00 09:25 [DOE JOHN, PT]

GAIT DEVICE:
Rolling walker. 03/21/00 09:25 [DOE JOHN, PT]

GAIT DISTANCE:
20'-50'. 03/21/00 09:25 [DOE JOHN, PT]

GAIT DEVIATION:
Very slow pace. 03/21/00 09:25 [DOE JOHN, PT]

ENDURANCE:
Fair plus. 03/21/00 09:25 [DOE JOHN, PT]

ASSESSMENT:
Good motivation and cooperation, Good progress anticipated, Good family support. 03/21/00 09:25 [DOE JOHN, PT]
03/21/00 09:25 [DOE JOHN, PT]

PLAN:
Transfer training, Balance training, Progressive gait training, Pain relief modalities. 03/21/00 09:25 [DOE JOHN, PT]
03/21/00 09:25 [DOE JOHN, PT]

SUPERVISED BY:
John Doe, PT 03/21/00 09:25 [DOE JOHN, PT]

Nurse's signature: _____

PATIENT:	WALSH KIERAN	NUMBER:	100989	AGE:	49	SEX:	M	ROOM:	TS002	PAGE:	2

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Displays patient's name, admitting physician, age, sex, room number, and any drug allergies documented through the TruBridge EHR system. In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

- **Patient Information Box:** Displays the following:

Patient's name	Name (person to contact in an emergency)	
Birth date and age	Relation(of above person)	Sex
Address	Marital status	Phone
Occupation	Attending physician	Religion
Consulting physician	Chief Complaint	

27.5 Initial Physical Assessment

The Initial Physical Assessment is a document that includes information regarding the patient's initial vital signs and assessment of body systems. It can be printed at anytime during the patient's stay, but should be primarily printed after completion on the system. If modifications are made, the report should be printed again. The nursing staff or other disciplines can print the report, but the nurse assigned to the patient primarily prints it or staff who make modifications to the report. Printing the Initial Physical Assessment is mandatory, unless otherwise specified by hospital policy. The report is usually a permanent part of the patient's chart.

Description and Usage

The Initial Physical Assessment is a document that includes information regarding the patient's initial vital signs and assessment of body systems.

Initial Physical Assessment

Initial Physical Assessment - Multidisciplinary

INITIAL PHYSICAL ASSESSMENT
PHYSICAL THERAPY

WALSH KIERAN
ALLERGIES: No Known All
AGE: 15
SEX: F
ROOM: 012-1
M/R#: 012345

Page 1 of 1

Initial Vital Signs

Temp:	99.8 ORAL	04/19/00 09:40 (JONES, RN)
Pulse:	74	04/19/00 09:40 (JONES, RN)
Resp:	16	04/19/00 09:40 (JONES, RN)
B/P:	166/81	04/19/00 09:40 (JONES, RN)
Weight:	160 lbs	04/19/00 09:40 (JONES, RN)

Dx:
04/19/00 10:06 (SMITH D,LPTA) Fx Left Femur
Hx:
04/19/00 10:06 (SMITH D,LPTA) Falls.
CC:
04/19/00 10:06 (SMITH D,LPTA) Pain.
PMH:
04/19/00 10:06 (SMITH D,LPTA) Fx of _Rt_Ankle_.
Previous Status:
04/19/00 10:06 (DOE J,PT) Total dependence.
MMT:
04/19/00 10:06 (DOE J,PT) Guarded affected extremity with pain.
Sensation:
04/19/00 10:06 (DOE J,PT) Impaired-light touch.
ROM:
04/19/00 10:06 (DOE J,PT) WNL unaffected extremities.
Gait:
04/19/00 10:06 (DOE J,PT) Maximum assistance.
Transfers and Bed Mobility:
04/19/00 10:06 (DOE J,PT) Moderate assistance, bed, chair.
Balance:
04/19/00 10:06 (DOE J,PT) Tandom gait: poor, due to diagnosis.
Treatment today:
04/19/00 10:06 (DOE J,PT) Transfer training, Gait training, ROM exercises.
Plan of Treatment:
04/19/00 10:06 (DOE J,PT) with axillary crutches FWB L. AARDM.
Gait,transfer,bed mobility training.
STG:
04/19/00 10:06 (DOE J,PT) Independent gait & transfers, Minimal assist.
LTG:
04/19/00 10:06 (DOE J,PT) Independent FWB L..
Frequency and duration:
04/19/00 10:06 (DOE J,PT) BID 5x/wk.

Nurse's signature:_____ Validated by:_____

PATIENT:	WALSH KIERAN	NUMBER:	357052	AGE:	15	SEX:	F	ROOM:	012-1	PAGE:	1

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Displays patient's name, admitting physician, age, sex, room number, and any drug allergies documented through the TruBridge EHR system. In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

- **Initial Vital Signs:** Will display the following:
  - Temperature (including site)
  - Pulse (including site)
  - Respiration
  - Blood Pressure (including posture and extremity)
  - Weight
  - The date, time, name and title of the person who charted the information.

- **Assessment Categories:** To be determined by Hospital or Multidiscipline Department.

Chapter 28 Nursing Order Report

The Nursing Orders report is a document that includes the patient's verified nursing orders and the current status of each order. It can be printed at anytime during the patient's stay, but it is primarily printed for the nursing assistants as a worksheet. Printing the Nursing Orders report is optional, unless otherwise specified by hospital policy. The report is commonly not a permanent part of the patient's chart and can be discarded after use.

28.1 How to Print

The Nursing Order Report may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart select the appropriate tab.
3. Select **Nursing Order Report**.
4. Select a patient by choosing "This Department", "My Patients", or "Current Patients."
5. Click patient name and then "Add Selected" to add patient to Patient Selection List
6. Select **Process**.

28.2 Description and Usage

The Nursing Orders report is a document that includes the patient's verified nursing orders and the current status of each order. It can be used as a worksheet by nursing aides to organize shift duties. It can be used by physicians to continue or discontinue orders on a transferring patient.

Nursing Orders Report

Evident Community Hospital

NURSING ORDERS

Printed: 12/18/17 at 11:32 Page 1 of 1

ABRAMS GREGG AGE: 88 SEX: M
WILLIAMS KERRI BUTTS ROOM: 010-2
ALLERGIES: Penicillin Tetracycline M/R#: 73-473

Cold pack to lower back
Apply cold pack TID
Have PT to assess daily
Verified 12/18/17 1130 (WILLIAMS K)

Air Mattress
Verified 12/18/17 1131 (WILLIAMS K)

Bed alarm
Verified 12/18/17 1131 (WILLIAMS K)

Call light in reach, bed in low position
Verified 12/18/17 1132 (WILLIAMS K)

PATIENT:	ABRAMS GREGG	NUMBER:	358213	AGE:	88	SEX:	M	ROOM:	010-2	PAGE:	1

Nursing Orders

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Patient's name, admitting physician, age, sex, room number, medical records number, and any drug allergies documented through the TruBridge EHR system. In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

- **Nursing Order Box:** Shaded in gray, each box displays one nursing order of up to three lines with a total of 225 characters.

- **Nursing Order Comment:** Displays any comment that was added, the last time the order was addressed.

- **Additional Notes:** Unverified nursing orders will NOT be included in this report. Nursing orders discontinued within eight hours of the printing of this report, will be included

Chapter 29 O2 Saturation Bar Graph

The O2 Sat Bar Graph is a document that displays the O2LM, FiO2, and O2SAT, which is graphed and includes the method. It can be printed at anytime during the patient's stay by the nursing staff, but the nurse assigned to the patient primarily prints it. Printing the O2 Sat Bar Graph is optional, unless otherwise specified by hospital policy. The report is usually not a permanent part of the patient's chart.

29.1 Description and Usage

The Problem Activity report is a document that includes the patient's identified problems and goals and all activity charted on each. It displays the path of progression toward resolution from the beginning of stay.

Problem Activity Report

Problem Activity Report

PROBLEM ACTIVITY

From beginning of stay TO: 03/20/02 08:20 Page 1 of 1

BOLTZ CAROLYN
BAXTER JAMES L
ALLERGIES: Penicillin Codeine

AGE: 54
SEX: F
ROOM: TS001
M/R#: 012345

03/19 16:20 GOAL (J. DOE, RN) PROBLEM 0 Knowledge Deficit R/T Disease Process

03/19 16:40 GOAL (J. DOE, RN) Instruct Patient on S/S of Disease Process ie. SOB/EDEMA/CP
Reinforce Importance of Keeping Follow-up Dr. Appt after Discharge.
Provide Information Regarding Community Resources.

Provide Information Regarding Community Resources.
03/20 07:48 GOAL (J. DOE, RN) Resolved
Pamphlets provided for Patient/Family.

Reinforce Importance of Keeping Follow-up Dr. Appt after Discharge.
03/20 07:52 GOAL (J. DOE, RN) Resolved
Appt made by JSD, RN. REminder given to Pt.

Instruct Patient on S/S of Disease Process ie. SOB/EDEMA/CP
03/20 07:53 GOAL (J. DOE, RN) Addressed
Will continue to reinforce teaching throughout admission.

Intervention

03/20 07:54 EDUC (J. DOE, RN) CARDIOPULMONARY
PATIENT INSTRUCTED ON:
Deep Breathing and Coughing Techniques, Use of the Incentive Spirometer, Pt Verbalizes Understanding.
EDUCATION DOCUMENTATION GIVEN TO: Patient, Significant Other.

Evaluation

03/20 08:20 EDUC (J. DOE, RN) CARDIOPULMONARY
PATIENT/FAMILY DEMONSTRATES:
Deep Breathing and Coughing Techniques, Proper Use of the Incentive Spirometer, Ability to Administer Respiratory Treatm.

03/19 16:40 PROB (J. DOE, RN) PROBLEM 0 Impaired Gas Exchange

03/19 16:40 GOAL (J. DOE, RN) Provide Comfort to Reduce Fear and Anxiety
Maintain High Fowlers Position
N.T. Suction if Secretions not Cleared by Cough

Intervention

03/20 07:00 RAC (J. DOE, RN) Pulmonary Treatments
Cough, turn and deep breathing exercises completed. Incentive Spirometer exercises completed. Pt tolerated _2000_mL. O2 (NC) at _2__L/min.

Maintain High Fowlers Position
03/20 07:57 GOAL (J. DOE, RN) Met

Provide Comfort to Reduce Fear and Anxiety
03/20 07:57 GOAL (J. DOE, RN) Addressed
Demonstrated comfort measures for Pt/SO.

Evaluation

03/20 07:58 P/A (J. DOE, RN) PULMONARY ASSESSMENT:
Respirations 12-22 per minute at rest. No acute distress. Respirations quiet and regular. No adventitious breath sounds. No cyanosis. CRT is less than 3 sec.

N.T. Suction if Secretions not Cleared by Cough
03/20 07:58 GOAL (J. DOE, RN) Addressed
No N.T. Suctioning required at this time.

Nurse's signature:_____(Last Page)

PATIENT:	BOLTZ CAROLYN	NUMBER:	100982	AGE:	54	SEX:	F	ROOM:	TS001	PAGE:	1

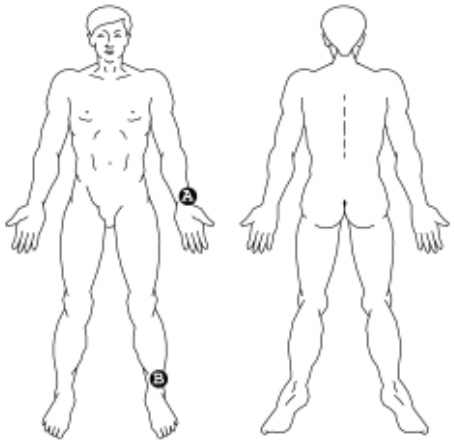
Unisex Body Report

Unisex Body Report

356959 BOLTZ CAROLYN
09/10/02 10:34 (JMD, RN) Wound location:

SITE A: Location: RT WRIST
Date First Observed: 09/09/02
Notes: 090902 0930 ORIF TO RT WRIST. FIBERCLASS CAST INTACT. NO EDEMA OR DRAINAGE NOTED.

SITE B: Location: RT ANKLE
Date First Observed: 09/09/02
Notes: 090902 0930 ORIF TO RT ANKLE. FIBERCLASS CAST INTACT. NO EDEMA OR DRAINAGE NOTED.



STAGE I : Site Red
Warm to Touch
Skin intact
STAGE II : Site Red
Site Warm to Touch
Slight tissue breakdown
STAGE III : Site Red
Site Warm to Touch
Tissue breakdown
Subcutaneous tissue exposed
Drainage noted
STAGE IV : Site Red
Site Warm to Touch
Muscle and/or bone exposed
Foul odor and/or drainabe noted

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Displays patient's name, admitting physician, age, sex, room number, medical record number, and any drug allergies documented through the TruBridge EHR system. In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

- **Problem List Box:** Shaded in gray, each box contains one problem order of up to seventy-five characters

- **Problem Activity:** Just below the problem box will be list of goals with date, time, and persons name of who entered goals. Following the goals will be the action taken related to the problem contained in a box. All goals and goal activity will follow the last action to the problem box in chronological order. All entries will be preceded by the date, time, and name of person who entered the information. The last action taken will appear in bold with comments listed below.

- **Problem List Status:** The status indicates the last action taken on the problem and will appear directly above the comment. The date and time will indicate the last time the problem was charted on and will display the name and title of the person who charted on the problem or goals.

- **Additional Notes:** Displays problems that have been resolved will display on this report.

- **Unisex Body Report:** An optional Unisex Body report can print along with the Problem Activity Report. This report will only print if a physical assessment question has been answered that allowed documentation of a wound, pain, or decubitus location on the unisex body. The report will list the marked sites (A-H) along with the site description(s). Also predefined Stage Descriptions will print at the bottom of the report. A switch located on the physical assessment questions controls whether or not the unisex body will display when the question is accessed. This is not a cumulative report.

NOTE: *Nursing Orders will display a total of three lines of characters with 75 characters on each line for a total of 225 characters.*

29.2 How to Print

The O2 Saturation Bar Graph may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.

2. From the Virtual Chart select the appropriate tab.

3. Select O2 Sat Bar Graph Report.

4. Select a patient by choosing "This Department", "My Patients", or "Current Patients."

5. Click patient name and then "Add Selected" to add patient to Patient Selection List

6. Select **Process**.

System prompts "Select Time Range for the O2 Saturation Bar Graph Report"

7. Select the time range that the report is needed.

8. Select **Print**.

29.3 Description and Usage

The O2 Sat Bar Graph is a document that displays the O2LM, FiO2, and O2SAT, which is graphed and includes the method.

O2 Saturation Bar Graph

O2 Sat Bar Graph Report

O2 Saturation Bar Graph

From beginning of stay TO: 04/05/00 14:46 Page 1 of 1

WALSH KIERAN
SHAPIRO VICKI
ALLERGIES: Penicillin Diazin
AGE: 49
SEX: M
ROOM: 900-B
M/R#: 012345

	O2LM	FiO2	O2SAT	10 20 30 40 50 60 70 80 90 100
04/01/00 08:15 (ALD RN)		49%	96%	VENTILATOR
04/01/00 16:32 (ALD RN)		40%	97%	VENTILATOR
04/02/00 08:14 (JDD RN)		40%	97%	Venti Mask
04/02/00 12:13 (JDD RN)		35%	96%	Venti Mask
04/02/00 16:12 (JDD RN)		35%	96%	Venti Mask
04/03/00 08:04 (AMJ RN)	3.0		97%	O2 Cannula
04/03/00 12:10 (CBA LPN)	3.0		99%	O2 Cannula
04/03/00 16:00 (CBA LPN)	2.0		98%	O2 Cannula
04/04/00 10:02 (AMJ RN)	1.0		98%	O2 Cannula
04/04/00 12:54 (AMJ RN)	1.0		98%	Room Air 21%

PATIENT: WALSH KIERAN NUMBER: 681659 AGE: 49 SEX: M ROOM: 900-B PAGE: 1

Listed below is an explanation of each column.

- **Demographics box (located upper right-hand corner):** Displays patient's name, account number, admitting physician, age, sex, room number, medical record number, and any drug allergies documented through the TruBridge EHR system.
- **O2 Information:** O2 L/M, FiO2, and O2 Sat values display numerically. O2 Sat values display as a bar graph. O2 Sat values display on the bar graph along with the method.

Chapter 30 Pain Assessment Flowsheet

The Pain Assessment Flowsheet is a document that includes specific patient information charted from the beginning of the patient's hospital stay to the minute it is printed on the system. It can be printed at anytime during the patient's stay by the nursing staff. Printing the Pain Assessment Flowsheet is optional, unless otherwise specified by hospital policy. The report is usually not a permanent part of the patient's chart and can be discarded after use.

30.1 How to Print

The Pain Assessment Flowsheet may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart select the appropriate tab.
3. Select **Pain Flow Sheet**.
4. Select a patient by choosing "This Department", "My Patients", or "Current Patients."
5. Click patient name and then "Add Selected" to add patient to Patient Selection List
6. Select **Process**.

Q. WHAT ARE THE SETUP OPTIONS FOR PRINTING?
A. The Pain Assessment Flowsheet can be set up to print:

- as part of end-of-shift reports
- as part of discharge reports and designated for multiple copies
- to automatically print at a specific hour to a specific printer.

The code for this report is "PAF," which is set up in the Point of Care Department Table through Nursing Administration, Hospital Base menu-Master Selection-B-1-N.

30.2 Description and Usage

The Pain Assessment Flowsheet is a document that includes specific patient information charted from the beginning of the patient's hospital stay to the minute it is printed on the system. This flowsheet provides both nurses and physicians details of the patient's pain status and any associated documentation.

Pain Assessment Flowsheet

Pain Assessment Flowsheet

Pain Assessment Flowsheet

From beginning of stay TO: 08/20/02 10:43 Page 1 of 1

BOLTZ CAROLYN
JAMES BAXTER, MD
ALLERGIES: Penicillin

AGE: 57
SEX: F
ROOM: 100-B
M/R#: 035861

			Assigned Pain Value	1 2 3 4 5 6 7 8 9 10
08/20/02 06:41 (DOE, RN)			2	
08/20/02 08:54 (DOE, RN)			8	
08/20/02 09:20 (DOE, RN)			0	
08/20/02 06:41 (DOE, RN)	(TPR)	Blood Pressure	112/78 LYING	
08/20/02 06:41 (DOE, RN)	(TPR)	Respiration	14	
08/20/02 06:41 (DOE, RN)	(TPR)	Pulse	68	
08/20/02 06:41 (DOE, RN)	(TPR)	Temperature	98.8 TYMPANIC	
08/20/02 08:54 (DOE, RN)	(P/A)	PAIN ASSESSMENT:	Patient complains of: severe pain, acute pain, incisional pain. location_ABDOMINAL_____.	
08/20/02 08:54 (DOE, RN)	(P/A)	PAIN ASSESSMENT:	*Duration: _20_____minutes.	
08/20/02 08:56 (DOE, RN)	(TPR)	Temperature	99.9 TYMPANIC	
08/20/02 08:56 (DOE, RN)	(TPR)	Pulse	88	
08/20/02 08:56 (DOE, RN)	(TPR)	Respiration	18	
08/20/02 08:56 (DOE, RN)	(TPR)	Blood Pressure	126/88 LYING	
08/20/02 09:04 (DOE, RN)	(MED)	PRN Medication MEPERIDINE HC	Given RIGHT DORSOGLUTEAL Dose: 50 MG 1X:N Comment: PAIN	
08/20/02 09:04 (DOE, RN)	(MED)	PRN Medication PROMETHAZINE	Given RIGHT DORSOGLUTEAL Dose: 25 MG 1X:N Comment: PAIN	
08/20/02 09:20 (DOE, RN)	(P/A)	PAIN ASSESSMENT:	Patient complains of: NO PAIN AT THIS TIME.	
08/20/02 09:20 (DOE, RN)	(P/A)	PAIN ASSESSMENT:	Relieving factors Pain medicine, IM DEMEROL/PHENERGAN	
08/20/02 09:20 (DOE, RN)	(P/A)	PAIN ASSESSMENT:	Pts response to pain management: Intervention_IM_MEDS_AS_ORDERED_____, Pain relieved, Pain controlled. NO PAIN AT THIS TIME.	

PATIENT: BOLTZ CAROLYN NUMBER: 500012 AGE: 57 SEX: F ROOM: 100-B PAGE: 1

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Displays patient's name, patient account number, admitting physician, age, sex, room number, medical record number, and any drug allergies documented through the TruBridge EHR system.

- **Entries:** Displays a pain scale value from 0-10 that was charted via the Pain Scale, any documented vital sign, physical assessment, activity or medication flag to print to the Pain Assessment Flowsheet, preceded by the following:
  - Date and time the entry was charted
  - The name and title of the individual who entered the information
  - Two to 3-character code indicating the application in which the entry was charted

Chapter 31 Patient Account Detail Report - Floor Stock Report

The Floor Stock Report has been changed so that when the Floor Stock Report is selected from the Virtual Chart, the Charging Review Screen is launched. From the Charging Review Screen, user can select Account Detail to see a list of charges on the account. This report may be viewed/printed in PDF format.

Please see the Charging User Guide for more information.

Chapter 32 Patient Census

The Patient Census is a document that includes specific patient information charted within the previous eight or twelve hours from the minute it is printed on the system. It can be printed at anytime during the patient's stay, but it is primarily printed at end of shift for nursing supervisors. Printing the Patient Census is optional, unless otherwise specified by hospital policy. The report is usually not a permanent part of the patient's chart and can be discarded after use.

32.1 How to Print

The Patient Census may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.

2. From the Virtual Chart select the appropriate tab.

3. Select Patient Census.

   System prompts, "Print Report By:"
   Patient
   Physician

   If **Patient** is selected:

   A. Select a patient by choosing "This Department", "My Patients", or "Current Patients."

   B. Click patient name and then "Add Selected" to add patient to Patient Selection List

   If **Physician** is selected:

   A. Select a Physician by typing in a physician's name or checking "All Physicians" and choosing a physician.

   B. Click the Physician name and then "Add Selected" to add physician to Physician Selection List

   C. The Patient Census can be processed for "Your Dept Only" or "All Depts" by selecting the appropriate radio button.

4. Select **Process.**

   System prompts "Enter Number of Copies to Print"

5. Enter the number of reports to print.

6. Select **OK**.

Q. WHAT ARE THE SETUP OPTIONS FOR PRINTING?
A. The Patient Census can be set up to print:

- as part of end-of-shift reports

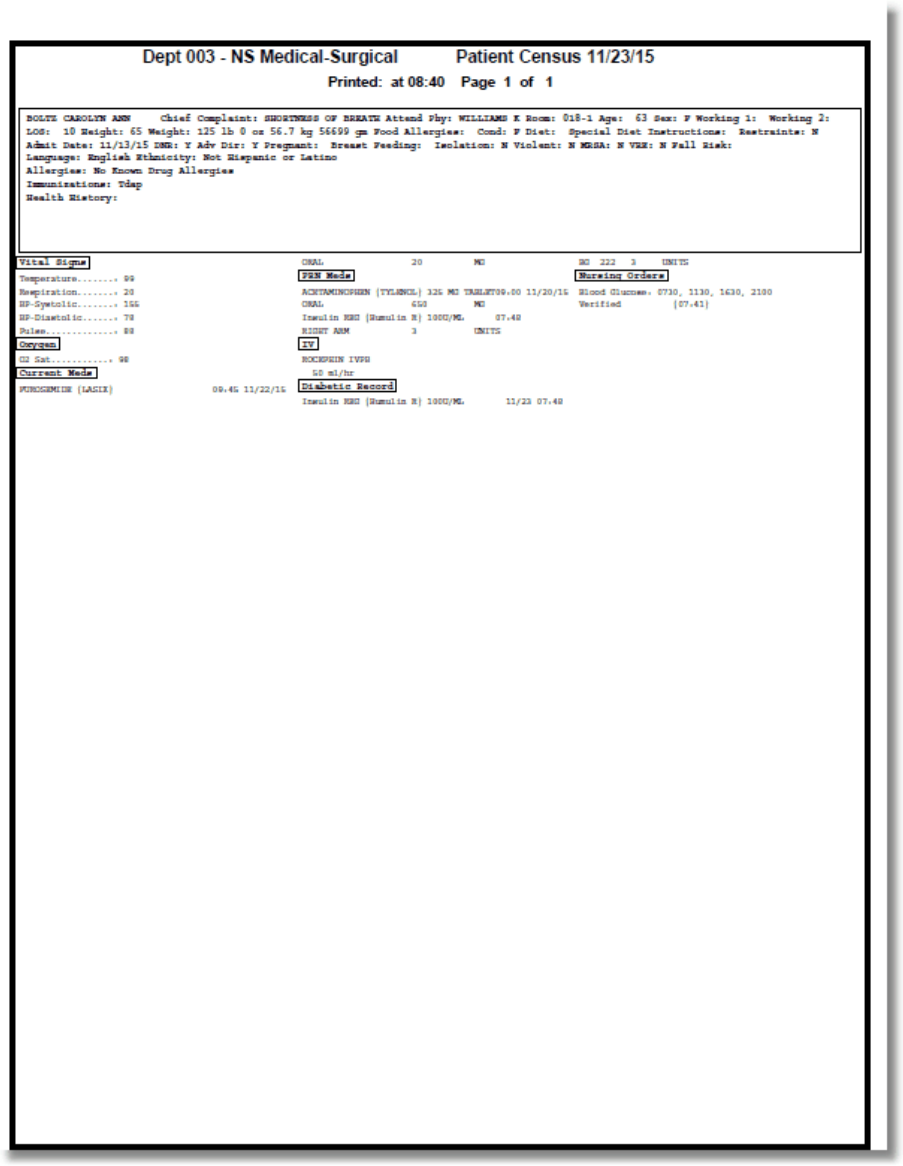
- to automatically print at a specific hour to a specific printer

The code for this report is “PC,” that is set up in the Point of Care Department Table through Nursing Administration, Hospital Base Menu-Master Selection-B-1-N. The report can be customized per nursing department from the Nursing Department, Hospital Base menu-Print Reports-P-chart type-8 and W.) (The Patient Census is more detailed on each patient than the Regular or Mini Nursing Station Census that is printed from the Nursing Department, Hospital Base menu-Print Reports -2 or 3.)

32.2 Description and Usage

The Patient Census is a document that includes specific patient information charted within the previous eight or twelve hours from the minute it is printed on the system. This report provides the nursing staff with details of the patient’s condition and plan of care. It is a primary tool used by the nursing supervisor at shift change.

Patient Census



Dept 003 - NS Medical-Surgical Patient Census 11/23/15

Printed: at 08:40 Page 1 of 1

BOLTE CAROLYN ANN Chief Complaint: SHORTNESS OF BREATH Attend Phy: WILLIAMS K Room: 018-1 Age: 63 Sex: F Working 1: Working 2:
LOS: 10 Weight: 65 Weight: 125 lb 0 oz 56.7 kg 56699 gm Food Allergies: Cond: F Diet: Special Diet Instructions: Restraints: N
Admit Date: 11/13/15 DNR: Y Adv Dir: Y Pregnant: Breast Feeding: Isolation: N Violent: N MRSA: N VRE: N Fall Risk:
Language: English Ethnicity: Not Hispanic or Latino
Allergies: No Known Drug Allergies
Immunizations: Tdap
Health History:

Vital Signs
Temperature..... 99
Respiration..... 20
BP-Systolic..... 155
BP-Diastolic..... 78
Pulse..... 88
Oxygen
O2 Sat..... 98
Current Meds
FUROSEMIDE (LASIX) 09.45 11/22/15

ORAL 20 MG
PRN Meds
ACETAMINOPHEN (TYLENOL) 325 MG TABLET09.00 11/20/15
ORAL 650 MG
Insulin REG (Humulin R) 100U/ML 07.48
RIGHT ARM 3 UNITS
IV
HOMEPHIN IVPB
50 ml/hr
Diabetic Record
Insulin REG (Humulin R) 100U/ML 11/23 07.48

NS 222 3 UNITS
Nursing Orders
Blood Glucose: 0730, 1130, 1630, 2100
Verified (07.41)

Listed below is an explanation of each column.

- **Demographics:** Displays the following:
  - Chief Complaint
  - Age
  - Working Diagnosis 2
  - Weight
  - Diet
  - Drug Allergies
  - Advance Directive
  - Isolation
  - VRE
  - Ethnicity
  - Attending Physician
  - Sex
  - Length of Stay
  - Food Allergies
  - Special Instructions
  - Admit Date
  - Pregnant
  - Violent Patient
  - Fall Risk
  - Immunization
  - Room
  - Working Diagnosis 1
  - Height
  - Condition Code
  - Restraints
  - DNR
  - Breast Feeding
  - MRSA
  - Language

- **Vital Signs:** Displays most recent temperature, pulse, respirations, and blood pressure display numerically.

- **O2:** Displays most recent O2 L/M and O2 Sat values display numerically.

- **Intake:** The user determines if the intake will display in total or detail. If detail and total is chosen, then 3 out of 11 options can be selected to display on the report. If intake other than what was selected for the detail options is charted on the patient, it will display as “other.” If total is selected in the setup, the total displays on the report. If detail is selected in the setup, the detail and total display on the report. Pediatric and Nursery chart types will include a breast feeding section if recorded.

- **Output:** The user determines if the output will display in total or detail. If detail and total is chosen, then 3 of 14 options can be selected to display on the report. If output other than what was selected for the detail options is charted on the patient, it will display as “other.” If total is selected in the setup, the total displays on the report. If detail is selected in the setup, the detail and total display on the report.

- **Current Medications:** Displays the description and status (“not administered” or if administered, route/site, quantity, unit, and administered time) of the medication displays on the report.

- **X1 (one-time) Medications:** Displays the description and status (“not administered” or route, quantity, unit, administered time) of the medication displays on the report.

- **PRN Medications:** Displays the description and status (“not administered” or if administered, route/site, quantity, unit, administered time) of the medication displays on the report.

- **Future Medications:** Displays the description and details (quantity, unit, route, flow rate, start date and time) of the medication displays on the report.

- **IV Information:** Displays the description, flow rate, description of insulin, quantity, unit, administered date and time, blood sugar level or “no insulin given,” blood sugar, intervention, charted date and time. Will also display alternating IV orders will be flagged with "***ALTERNATING IV SET 1***" or "Alt. IV Set 1***", with the number being the order number from the patient's pharmacy profile.

- **Flagged Abnormals**

- **Distinctive Physical Assessments:** Displays assessments charted within the eight or 12 hour period covered, that are flagged as distinctive and is noted by the medical staff. Will also display the date and time of entry. In order for this information to be reflected, it must be set up by Nursing Administration.

- **Distinctive Nursing Assessments:** Displays assessments charted within the eight or twelve hour period covered, that are flagged as distinctive and be noted by the medical staff as well as the date and time of entry. In order for this information to be reflected, it must be set up by Nursing Administration.

- **Flagged Nursing Orders:** Displays status and time of entry or documentation. In order for this information to be reflected, it must be set up by Nursing Administration. Nursing order description fields have been expanded to include up to three lines of 75 characters on each line (225 characters total).

Chapter 33 Patient Drug Information

Please refer to the Patient Education Documents User Guide for information on this topic.

Chapter 34 Patient Education Documents

Please refer to the Patient Education Documents User Guide for information on this topic.

Chapter 35 Patient Medical Summaries (CCDA

Please refer Patient Medical Summaries (CCDA) User Guide for information on this topic.

Chapter 36 Patient Progress Notes

The Patient Progress Notes is a document that includes information from most POC applications charted during a given time frame. It can be printed at anytime during the patient's stay, but should be printed at the end of each shift and at patient discharge. The nursing staff can print the report; however, the nurse assigned to the patient can print the Patient Progress Notes, via the option, End of Shift. Printing the Patient Progress Notes is mandatory, unless otherwise specified by hospital policy. The report is usually a permanent part of the patient's chart.

36.1 How to Print

The Initial Physical Assessment may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart select the appropriate tab.
3. Select **Patient Progress Notes**.
4. System prompts, "View Patient Progress Notes"
5. Enter a start date and end date or choose to print from beginning of stay.
6. Select Begin Viewing

   System prompts "Include stricken/amended data?"
7. This option will include any stricken or amended data in the report.

36.2 Description and Usage

The Patient Progress Notes is a document that includes information from most POC applications charted during a given time frame. The Initial Interview and Initial Physical Assessment are not included in the Patient Progress Notes. Documentation from the multi-disciplinary applications prints to the report, also. It is printed at the end of shift and signed by the nurse assigned to the patient.

NOTE: *If a user has the behavior control "**Amend MAR Documentation for Any Login**," any super amended documentation performed in the **Updated EMAR** will display on Patient Progress Notes along with the date/time and reason.*

Patient Progress Notes - Format A - Page 1

Patient Progress Notes – Format A – Page 1

PATIENT PROGRESS NOTES

FROM: 05/18/04 06:56 TO: 05/19/04 10:28 Page 1 of 8

ANDERS NEIL
BARNES PATRICK
ALLERGIES: No Known Drug

AGE: 29
SEX: M
ROOM: 501
M/R#: 897946562

05/18/04

07:00 BGM (J DOE, RN) BLOODGLUC 175 SQ

07:00 MED (J DOE, RN) PRN Medication Given RIGHT ARM Dose: 2 UN
INSULIN 50/50 (HUMULIN) VIAL 1X:N

07:30 MED (J DOE, RN) PRN Medication Given INJECTION Dose: 100 MG
MEPERIDINE (DEMEROL) INJ 1X:N Reason: PAIN

07:30 MED (J DOE, RN) PRN Medication Given INJECTION Dose: 25 MG
PHENERGAN (PROMETHAZINE) 1X:N Reason: NAUSEA

08:25 MO (J DOE, RN) Recorded Medical Order 75% CONSUMED
LOW SODIUM
START MEAL: _LUNCH_____ START DATE: _020404___

09:06 MED (J DOE, RN) Routine Medication Given ORAL Dose: 20 MG
LASIX (FUROSEMIDE) TB 1X:N

09:06 MED (J DOE, RN) Routine Medication Given ORAL Dose: 200 MCG
LANOXICAPS (DIGOXIN) CP 1X:N

09:06 MED (J DOE, RN) IV Medication Given IV PIGGY Rate: 100 ml/hr
Dose: 50 ML
ANCEF 1GM/50ML D5W INFUSE OVER 30 MINUTES 1X:N

09:07 MED (J DOE, RN) IV Medication Started RIGHT HAND Rate: 100 ml/hr
Dose: 1000 ML
D5 NS 1000ML 1X:N

09:21 P/A (J DOE, RN) **INJURY RISK ASSESSMENT:**
Call bell within reach: yes, Bed exit armed.
Arm band is on patient's wrist and labeled properly: yes.
Significant other at bedside: siblings, wife.
Assistive devices: none.
Safety Measures: Side rails up x4.
Care Needs Range of Motion/Assisted mobility.
Bed exit armed yes.
Safety/Risk Assessment Orientation: Good
alert and orientated, usually free of major health problems, illness/injury does not impede activity.
Safety/Risk Assessment Sensory: Good
hearing normal, skin sensation normal.
Safety/Risk Assessment Mobility: Good
continent of urine, continent of bowels.
Safety/Risk Assessment Mobility: Fair up with assistance.

09:23 P/A (J DOE, RN) **PSYCHOSOCIAL ASSESSMENT:**
Patient is awake, alert and oriented to person, place, and time. Behavior is appropriate to situation.

09:24 P/A (J DOE, RN) **CARDIOVASCULAR ASSESSMENT:**
Heart tones normal per auscultation. No murmur noted. Heart rate regular. Pulses palpable at all extremeties. No edema noted. Skin warm to touch. Mucous membranes moist and pink.

09:24 P/A (J DOE, RN) **PULMONARY ASSESSMENT:**
Respirations 12 to 22 per minute at rest. No acute distress. Respirations quiet and regular. No adventitious breath sounds. No cyanosis.

09:24 P/A (J DOE, RN) **NEUROLOGICAL ASSESSMENT:**
Pupils: PERRLA.
Motor strength: right leg, weak, right arm, left arm, strong, equal.
Cough Reflex: normal.

Nurse's signature:_____

PATIENT: ANDERS NEIL NUMBER: 401247 AGE: 29 SEX: M ROOM: 501 PAGE: 1

Patient Progress Notes - Format A - Page 2

Patient Progress Notes – Format A – Page 2

PATIENT PROGRESS NOTES

FROM: 05/18/04 06:56 TO: 05/19/04 10:28 Page 2 of 8

ANDERS NEIL
BARNES PATRICK
ALLERGIES: No Known Dru

AGE: 29
SEX: M
ROOM: 501
M/R#: 897946562

Eyes: clear.

09:25 P/A (J DOE, RN) **NEUROLOGICAL ASSESSMENT:**
Neurological history: Hand grasp, equal.
Gag reflex: Present.
Pupils: equal, Reactive.
Level of consciousness: alert, oriented x 3.
Speech: clear.

09:25 P/A (J DOE, RN) **METABOLIC/INTEGUMENT ASSESSMENT:**
Skin color WNL.
Skin condition: intact, cool.
Turgor: fair turgor, edema.
Dressing: dry, intact.
Mucous membranes: moist, pink.

09:26 P/A (J DOE, RN) **MUSCULOSKELETAL ASSESSMENT:**
Fall Precautions: yes.
Moves all extremities: yes.
Walks unaided: unsteady.
Walks aided by: hold on assist.
Hand grasps: equal, strong.
Leg strength: right sided weakness.
Sensations: C/O pain.
Sprain: right, ankle.
Muscle spasms: right, leg.
Arthritis: right, knee.
Inflammation of Joints: right, knee, ankle.

09:27 P/A (J DOE, RN) **GASTROINTESTINAL ASSESSMENT:**
Abdomen soft, nontender, nondistended, with bowel sounds in all four quadrants. No c/o nausea and/or vomiting. Tolerating PO intake well.

09:27 P/A (J DOE, RN) **GENITOURINARY ASSESSMENT:**
Patient denies complaint of pain, burning, frequency, hesitancy or itching when voiding. Bladder is nondistended. Urine is clear and yellow to amber in color.

09:28 P/A (J DOE, RN) **INTRAVENOUS ASSESSMENT:**
IV intact with no redness or swelling at site. Patient denies discomfort.

09:28 P/A (J DOE, RN) **PAIN ASSESSMENT:**
Pain Scale (0-10) 5
Duration: _45_____minutes.
Relieving factors Pain medicine, Relaxation techniques.
Pts response to pain management intervention: Pain controlled.

09:28 P/A (J DOE, RN) **WOUND ASSESSMENT:**
Type of wound: surgical incision.
Appearance of Wound: Pink.
Wound is approximated: no inflammation.
Wound open to air: no.
Drainage: none.
Odor: none.
Dressing: clean, dry, intact.
LOCATION: RIGHT LEG.

09:28 P/A (J DOE, RN) **REPRODUCTIVE ASSESSMENT:**
Patient does not express sexual dysfunction and/or inadequacy.

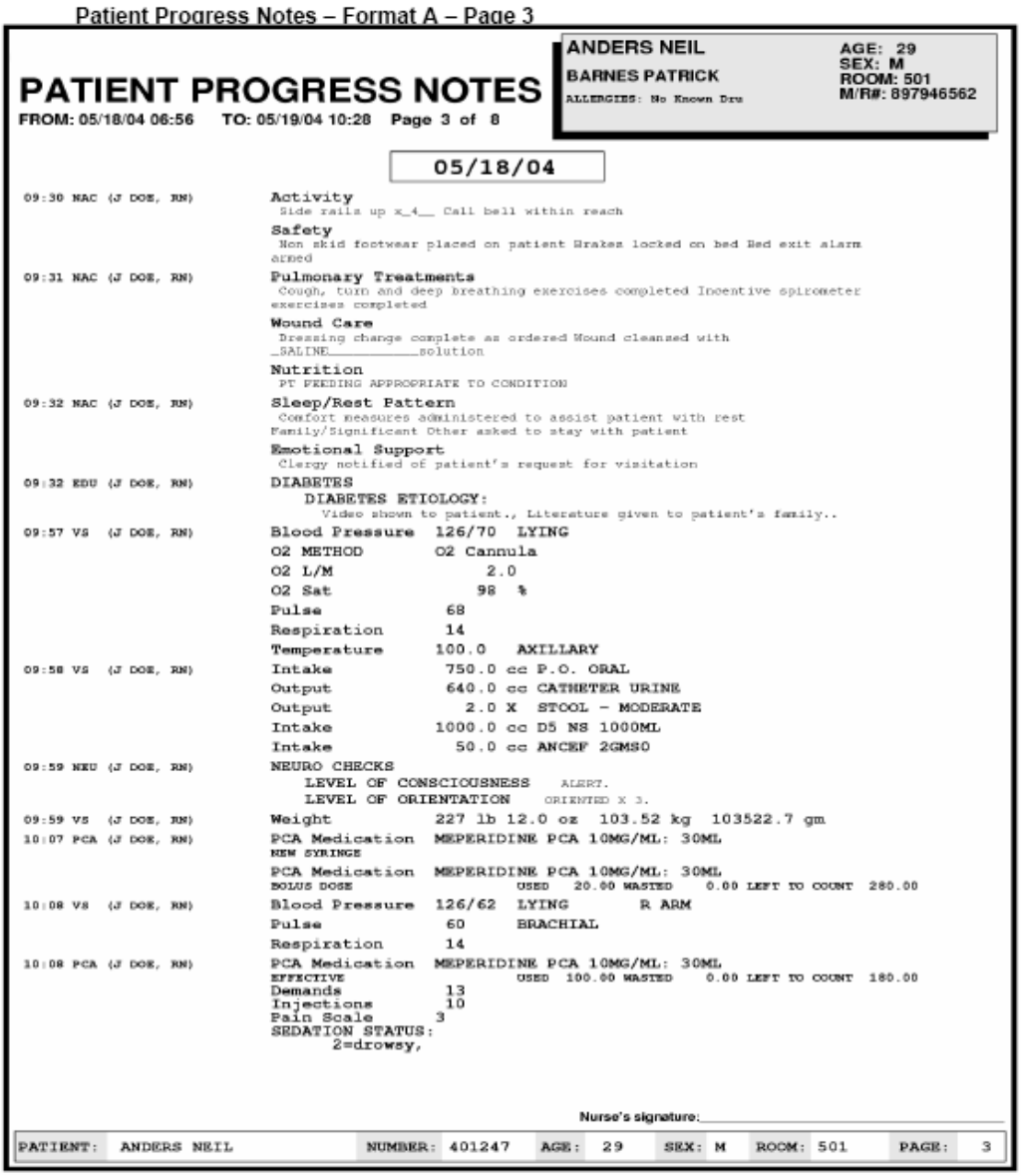
09:29 NAC (J DOE, RN) **Hygiene**
AM care provided Back rub given Bed linen changed

09:30 NAC (J DOE, RN) **Activity**

Nurse's signature:_____

PATIENT:	ANDERS NEIL	NUMBER:	401247	AGE:	29	SEX:	M	ROOM:	501	PAGE:	2

Patient Progress Notes - Format A - Page 3



Patient Progress Notes – Format A – Page 3

PATIENT PROGRESS NOTES

FROM: 05/18/04 06:56 TO: 05/19/04 10:28 Page 3 of 8

ANDERS NEIL
BARNES PATRICK
ALLERGIES: No Known Drug

AGE: 29
SEX: M
ROOM: 501
M/R#: 897946562

05/18/04

09:30 NAC (J DOE, RN) **Activity**
Side rails up x_4__ Call bell within reach

Safety
Non skid footwear placed on patient Brakes locked on bed Bed exit alarm armed

09:31 NAC (J DOE, RN) **Pulmonary Treatments**
Cough, turn and deep breathing exercises completed Incentive spirometer exercises completed

Wound Care
Dressing change complete as ordered Wound cleansed with _SALINE_____solution

Nutrition
PT FEEDING APPROPRIATE TO CONDITION

09:32 NAC (J DOE, RN) **Sleep/Rest Pattern**
Comfort measures administered to assist patient with rest
Family/Significant Other asked to stay with patient

Emotional Support
Clergy notified of patient's request for visitation

09:32 EDU (J DOE, RN) DIABETES
DIABETES ETIOLOGY:
Video shown to patient., Literature given to patient's family..

09:57 VS (J DOE, RN)
Blood Pressure 126/70 LYING
O2 METHOD O2 Cannula
O2 L/M 2.0
O2 Sat 98 %
Pulse 68
Respiration 14
Temperature 100.0 AXILLARY

09:58 VS (J DOE, RN)
Intake 750.0 cc P.O. ORAL
Output 640.0 cc CATHETER URINE
Output 2.0 X STOOL - MODERATE
Intake 1000.0 cc D5 NS 1000ML
Intake 50.0 cc ANCEF 2GMSO

09:59 NEU (J DOE, RN) NEURO CHECKS
LEVEL OF CONSCIOUSNESS ALERT.
LEVEL OF ORIENTATION ORIENTED X 3.

09:59 VS (J DOE, RN)
Weight 227 lb 12.0 oz 103.52 kg 103522.7 gm

10:07 PCA (J DOE, RN)
PCA Medication MEPERIDINE PCA 10MG/ML: 30ML
NEW SYRINGE

PCA Medication MEPERIDINE PCA 10MG/ML: 30ML
BOLUS DOSE USED 20.00 WASTED 0.00 LEFT TO COUNT 280.00

10:08 VS (J DOE, RN)
Blood Pressure 126/62 LYING R ARM
Pulse 60 BRACHIAL
Respiration 14

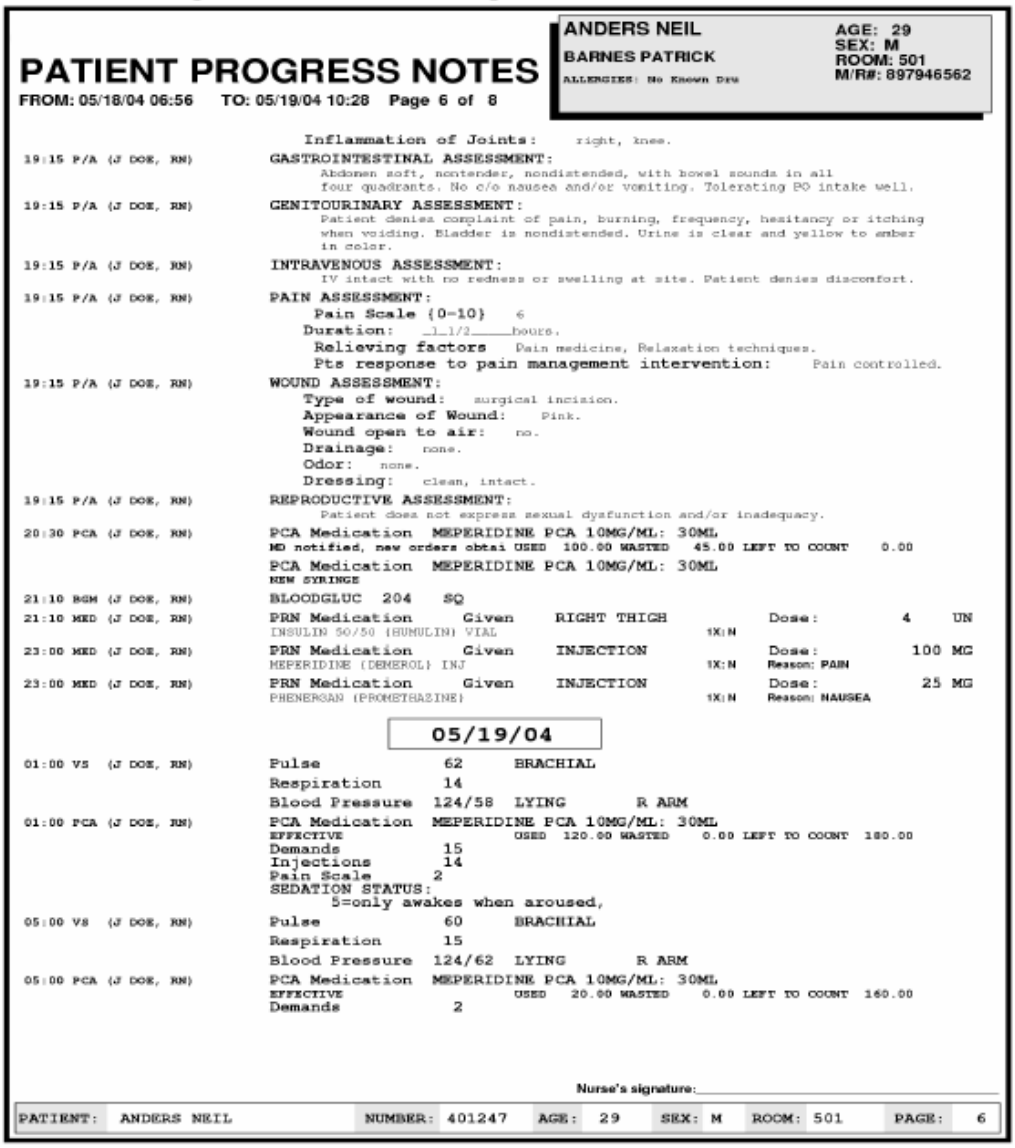
10:08 PCA (J DOE, RN)
PCA Medication MEPERIDINE PCA 10MG/ML: 30ML
EFFECTIVE USED 100.00 WASTED 0.00 LEFT TO COUNT 180.00
Demands 13
Injections 10
Pain Scale 3
SEDATION STATUS:
2=drowsy,

Nurse's signature:_____

PATIENT: ANDERS NEIL NUMBER: 401247 AGE: 29 SEX: M ROOM: 501 PAGE: 3

Patient Progress Notes - Format A - Page 4

Patient Progress Notes – Format A – Page 4



PATIENT PROGRESS NOTES
FROM: 05/18/04 06:56 TO: 05/19/04 10:28 Page 6 of 8

ANDERS NEIL
BARNES PATRICK
ALLERGIES: No Known Drug
AGE: 29
SEX: M
ROOM: 501
M/R#: 897946562

Inflammation of Joints: right, knee.

19:15 P/A (J DOE, RN) GASTROINTESTINAL ASSESSMENT:
Abdomen soft, nontender, nondistended, with bowel sounds in all four quadrants. No c/o nausea and/or vomiting. Tolerating PO intake well.

19:15 P/A (J DOE, RN) GENITOURINARY ASSESSMENT:
Patient denies complaint of pain, burning, frequency, hesitancy or itching when voiding. Bladder is nondistended. Urine is clear and yellow to amber in color.

19:15 P/A (J DOE, RN) INTRAVENOUS ASSESSMENT:
IV intact with no redness or swelling at site. Patient denies discomfort.

19:15 P/A (J DOE, RN) PAIN ASSESSMENT:
Pain Scale (0-10) 6
Duration: 1 1/2 hours.
Relieving factors Pain medicine, Relaxation techniques.
Pts response to pain management intervention: Pain controlled.

19:15 P/A (J DOE, RN) WOUND ASSESSMENT:
Type of wound: surgical incision.
Appearance of Wound: Pink.
Wound open to air: no.
Drainage: none.
Odor: none.
Dressing: clean, intact.

19:15 P/A (J DOE, RN) REPRODUCTIVE ASSESSMENT:
Patient does not express sexual dysfunction and/or inadequacy.

20:30 PCA (J DOE, RN) PCA Medication MEPERIDINE PCA 10MG/ML: 30ML
MD notified, new orders obtai USED 100.00 WASTED 45.00 LEFT TO COUNT 0.00

PCA Medication MEPERIDINE PCA 10MG/ML: 30ML
NEW SYRINGE

21:10 BGM (J DOE, RN) BLOODGLUC 204 SQ

21:10 MED (J DOE, RN) PRN Medication Given RIGHT THIGH Dose: 4 UN
INSULIN 50/50 (HUMULIN) VIAL 1X:N

23:00 MED (J DOE, RN) PRN Medication Given INJECTION Dose: 100 MG
MEPERIDINE (DEMEROL) INJ 1X:N Reason: PAIN

23:00 MED (J DOE, RN) PRN Medication Given INJECTION Dose: 25 MG
PHENERGAN (PROMETHAZINE) 1X:N Reason: NAUSEA

05/19/04

01:00 VS (J DOE, RN) Pulse 62 BRACHIAL
Respiration 14
Blood Pressure 124/58 LYING R ARM

01:00 PCA (J DOE, RN) PCA Medication MEPERIDINE PCA 10MG/ML: 30ML
EFFECTIVE USED 120.00 WASTED 0.00 LEFT TO COUNT 180.00
Demands 15
Injections 14
Pain Scale 2
SEDATION STATUS:
5=only awakes when aroused,

05:00 VS (J DOE, RN) Pulse 60 BRACHIAL
Respiration 15
Blood Pressure 124/62 LYING R ARM

05:00 PCA (J DOE, RN) PCA Medication MEPERIDINE PCA 10MG/ML: 30ML
EFFECTIVE USED 20.00 WASTED 0.00 LEFT TO COUNT 160.00
Demands 2

Nurse's signature:_____

PATIENT: ANDERS NEIL NUMBER: 401247 AGE: 29 SEX: M ROOM: 501 PAGE: 6

Patient Progress Notes - Format B - Page 1

Patient Progress Notes – Format B – Page 1

PATIENT PROGRESS NOTES

FROM: 05/25/04 06:51 TO: 05/26/04 07:15 Page 1 of 6

RICE STEPHEN ANDREW AGE: 29
BARNES PATRICK SEX: M
ALLERGIES: No Known Dru ROOM: 98-1
M/R#: 234972

VITAL SIGNS

05/25/04

08:00 VS (J DOE, RN)	Blood Pressure	129/70	LYING	R ARM		
	O2 Sat	97	%			
	Pulse	68	BRACHIAL			
	Respiration	16				
	Temperature	100.5	ORAL			
	Weight	178 lb		80.91 kg	80909.1 gm	
	Weight	178 lb		80.91 kg	80909.1 gm	Floor scale
16:00 VS (J DOE, RN)	Blood Pressure	124/70	LYING	R ARM		
	O2 METHOD	O2 Cannula				
	O2 L/M	2.0				
	O2 Sat	97	%			
	Intake	450.0	cc P.O. ORAL			
	Intake	1000.0	cc D5 1/2 NS 20MEQ KCL			
	Intake	100.0	cc ANCEF 1GM/50ML D5W			
	Output	650.0	cc VOIDED URINE			
	Output	1.0	X STOOL - MODERATE			
	Pulse	68	BRACHIAL			
	Respiration	14				
	Temperature	100.0	AXILLARY			
22:00 VS (J DOE, RN)	CVP	12.0				
	PAP	36/20				
	PAWP	9				
	Cardiac Output	5.00				
23:30 VS (J DOE, RN)	Blood Pressure	128/68	LYING	R ARM		
	O2 METHOD	O2 Cannula				
	O2 L/M	2.0				
	O2 Sat	98	%			
	Intake	650.0	cc P.O. ORAL			
	Intake	1000.0	cc D5 1/2 NS 20MEQ KCL			
	Intake	50.0	cc ANCEF 1GM/50ML D5W			
	Output	450.0	cc VOIDED URINE			
	Output	NONE	STOOL			
	Pulse	68	BRACHIAL			
	Respiration	14				
	Temperature	99.7	ORAL			

05/26/04

05:00 VS (J DOE, RN)	Blood Pressure	133/68	LYING	R ARM		
	O2 METHOD	O2 Cannula				
	O2 L/M	2.0				
	O2 Sat	98	%			

Nurse's signature:

PATIENT: RICE STEPHEN ANDREW NUMBER: 102090 AGE: 29 SEX: M ROOM: 98-1 PAGE: 1

Patient Progress Notes - Format B - Page 2

Patient Progress Notes – Format B – Page 2

PATIENT PROGRESS NOTES

FROM: 05/25/04 06:51 TO: 05/26/04 07:15 Page 2 of 6

RICE STEPHEN ANDREW AGE: 29
SEX: M
BARNES PATRICK ROOM: 98-1
ALLERGIES: No Known Dru M/R#: 234972

VITAL SIGNS

Intake	NONE	P.O. ORAL
Intake	450.0 cc	D5 1/2 NS 20MEQ KCL
Output	NONE	VOIDED URINE
Output	NONE	STOOL
Pulse	70	RADIAL
Respiration	14	
Temperature	100.2	ORAL

NURSING ACTIVITIES & SHIFT SUMMARY

05/25/04

12:20 NAC (J DOE, RN) Activity
Side rails up x_4__ Bed placed in low position Call bell within reach

14:00 NAC (J DOE, RN) Activity
Pt ambulates with family

MEDICAL ORDERS

08:00 MO (J DOE, RN) NOTED Medical Order
DO NOT RESUCITATE

13:00 MO (J DOE, RN) Recorded Medical Order 75% CONSUMED
REGULAR
START DATE: _052504_____ START TIME: _1200_____

18:00 MO (J DOE, RN) Recorded Medical Order 100% CONSUMED
REGULAR

EDUCATION

09:32 EDU (J DOE, RN) DIABETES
DIABETES ETIOLOGY:
Video shown to patient., Literature given to patient's family..

DIABETIC RECORD & PCA

10:07 PCA (J DOE, RN) PCA Medication MEPERIDINE PCA 10MG/ML: 30ML
NEW SYRINGE

PCA Medication MEPERIDINE PCA 10MG/ML: 30ML
BOLUS DOSE USED 20.00 WASTED 0.00 LEFT TO COUNT 280.00

10:08 PCA (J DOE, RN) PCA Medication MEPERIDINE PCA 10MG/ML: 30ML
EFFECTIVE USED 100.00 WASTED 0.00 LEFT TO COUNT 180.00
Demands 13
Injections 10
Pain Scale 3
SEDATION STATUS:
2=drowsy,

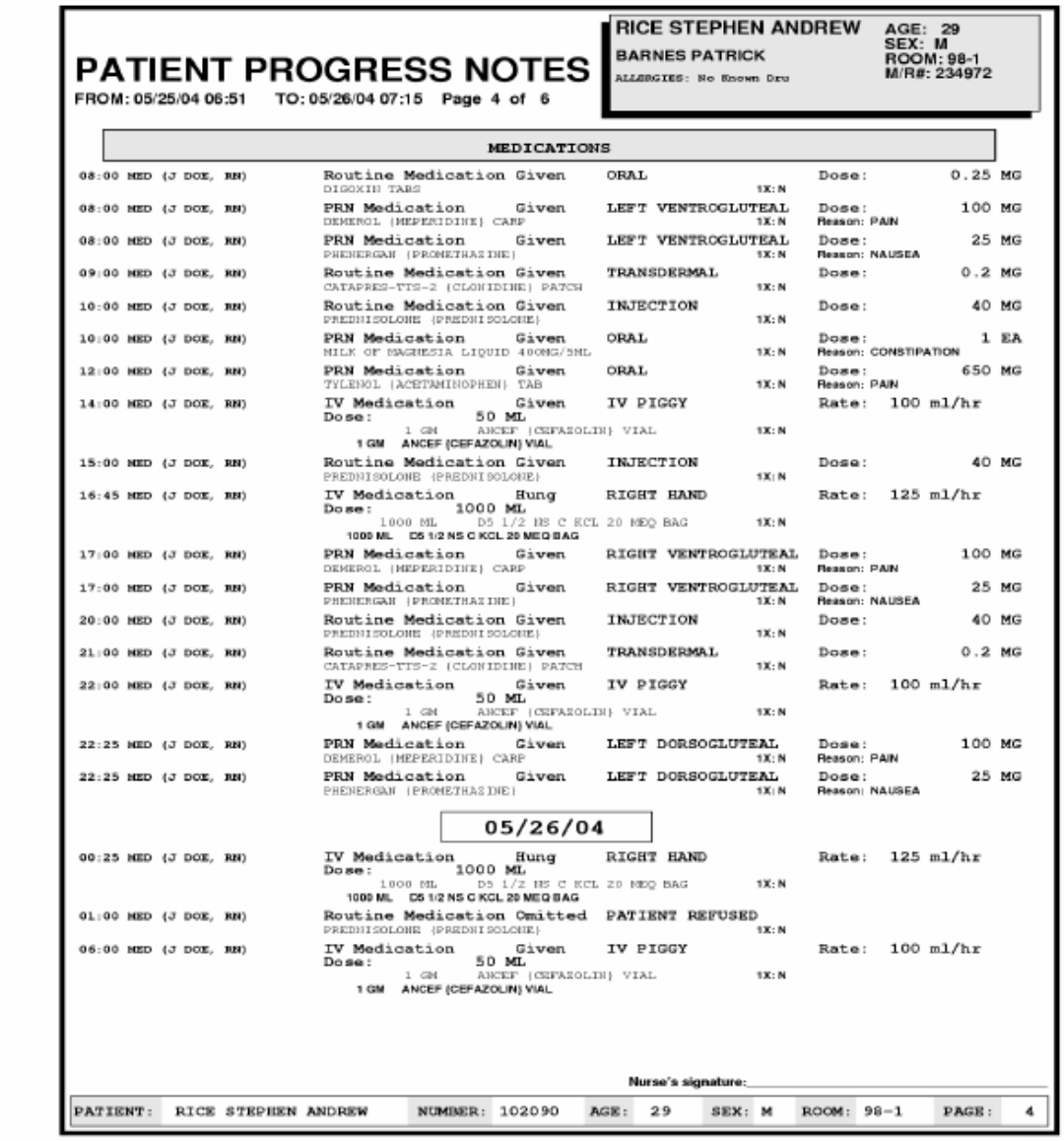
13:50 PCA (J DOE, RN) PCA Medication MEPERIDINE PCA 10MG/ML: 30ML
EFFECTIVE USED 160.00 WASTED 5.00 LEFT TO COUNT 0.00
Demands 20
Injections 16
Pain Scale 4
SEDATION STATUS:
3=dozing intermittently,

Nurse's signature:_____

PATIENT: RICE STEPHEN ANDREW NUMBER: 102090 AGE: 29 SEX: M ROOM: 98-1 PAGE: 4

Patient Progress Notes - Format B - Page 3

Patient Progress Notes – Format B – Page 3



PATIENT PROGRESS NOTES

FROM: 05/25/04 06:51 TO: 05/26/04 07:15 Page 4 of 6

RICE STEPHEN ANDREW AGE: 29
SEX: M
BARNES PATRICK ROOM: 98-1
ALLERGIES: No Known Dru M/R#: 234972

MEDICATIONS

08:00 MED (J DOE, RN)	Routine Medication Given DIGOXIN TABS	ORAL	1X:N	Dose:	0.25 MG
08:00 MED (J DOE, RN)	PRN Medication Given DEMEROL (MEPERIDINE) CARP	LEFT VENTROGLUTEAL	1X:N	Dose: Reason: PAIN	100 MG
08:00 MED (J DOE, RN)	PRN Medication Given PHENERGAN (PROMETHAZINE)	LEFT VENTROGLUTEAL	1X:N	Dose: Reason: NAUSEA	25 MG
09:00 MED (J DOE, RN)	Routine Medication Given CATAPRES-TTS-2 (CLONIDINE) PATCH	TRANSDERMAL	1X:N	Dose:	0.2 MG
10:00 MED (J DOE, RN)	Routine Medication Given PREDNISOLONE (PREDNISOLONE)	INJECTION	1X:N	Dose:	40 MG
10:00 MED (J DOE, RN)	PRN Medication Given MILK OF MAGNESIA LIQUID 400MG/5ML	ORAL	1X:N	Dose: Reason: CONSTIPATION	1 EA
12:00 MED (J DOE, RN)	PRN Medication Given TYLENOL (ACETAMINOPHEN) TAB	ORAL	1X:N	Dose: Reason: PAIN	650 MG
14:00 MED (J DOE, RN)	IV Medication Given Dose: 50 ML 1 GM ANCEF (CEFAZOLIN) VIAL 1 GM ANCEF (CEFAZOLIN) VIAL	IV PIGGY	1X:N	Rate:	100 ml/hr
15:00 MED (J DOE, RN)	Routine Medication Given PREDNISOLONE (PREDNISOLONE)	INJECTION	1X:N	Dose:	40 MG
16:45 MED (J DOE, RN)	IV Medication Hung Dose: 1000 ML 1000 ML D5 1/2 NS C KCL 20 MEQ BAG 1000 ML D5 1/2 NS C KCL 20 MEQ BAG	RIGHT HAND	1X:N	Rate:	125 ml/hr
17:00 MED (J DOE, RN)	PRN Medication Given DEMEROL (MEPERIDINE) CARP	RIGHT VENTROGLUTEAL	1X:N	Dose: Reason: PAIN	100 MG
17:00 MED (J DOE, RN)	PRN Medication Given PHENERGAN (PROMETHAZINE)	RIGHT VENTROGLUTEAL	1X:N	Dose: Reason: NAUSEA	25 MG
20:00 MED (J DOE, RN)	Routine Medication Given PREDNISOLONE (PREDNISOLONE)	INJECTION	1X:N	Dose:	40 MG
21:00 MED (J DOE, RN)	Routine Medication Given CATAPRES-TTS-2 (CLONIDINE) PATCH	TRANSDERMAL	1X:N	Dose:	0.2 MG
22:00 MED (J DOE, RN)	IV Medication Given Dose: 50 ML 1 GM ANCEF (CEFAZOLIN) VIAL 1 GM ANCEF (CEFAZOLIN) VIAL	IV PIGGY	1X:N	Rate:	100 ml/hr
22:25 MED (J DOE, RN)	PRN Medication Given DEMEROL (MEPERIDINE) CARP	LEFT DORSOGLUTEAL	1X:N	Dose: Reason: PAIN	100 MG
22:25 MED (J DOE, RN)	PRN Medication Given PHENERGAN (PROMETHAZINE)	LEFT DORSOGLUTEAL	1X:N	Dose: Reason: NAUSEA	25 MG

05/26/04

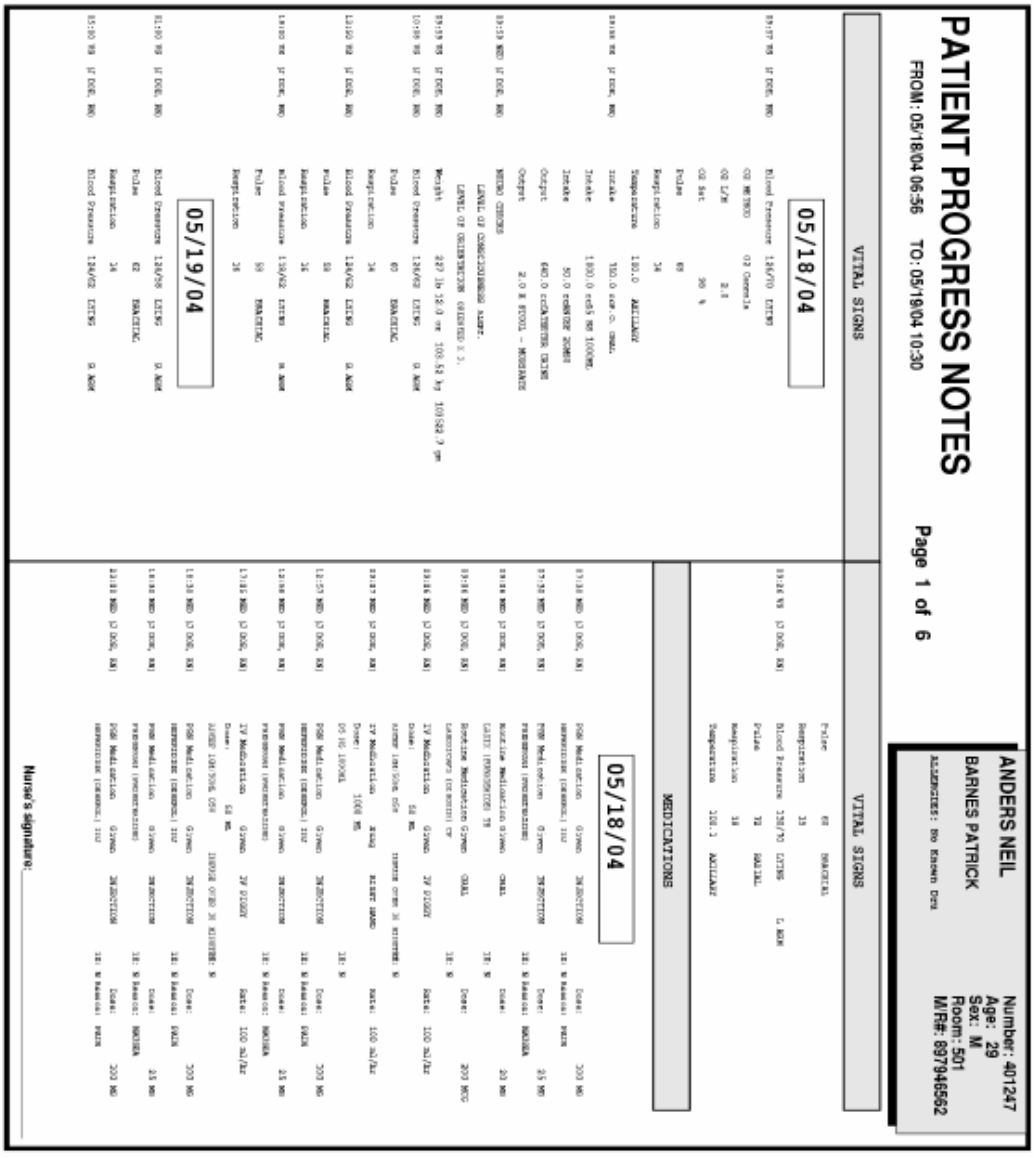
00:25 MED (J DOE, RN)	IV Medication Hung Dose: 1000 ML 1000 ML D5 1/2 NS C KCL 20 MEQ BAG 1000 ML D5 1/2 NS C KCL 20 MEQ BAG	RIGHT HAND	1X:N	Rate:	125 ml/hr
01:00 MED (J DOE, RN)	Routine Medication Omitted PREDNISOLONE (PREDNISOLONE)	PATIENT REFUSED	1X:N		
06:00 MED (J DOE, RN)	IV Medication Given Dose: 50 ML 1 GM ANCEF (CEFAZOLIN) VIAL 1 GM ANCEF (CEFAZOLIN) VIAL	IV PIGGY	1X:N	Rate:	100 ml/hr

Nurse's signature:_____

PATIENT: RICE STEPHEN ANDREW NUMBER: 102090 AGE: 29 SEX: M ROOM: 98-1 PAGE: 4

Patient Progress Notes - Format C - Page 1

Patient Progress Notes – Format C – Page 1



PATIENT PROGRESS NOTES

FROM: 05/18/04 06:56 TO: 05/19/04 10:30

Page 1 of 6

ANDERS NEIL
BARNES PATRICK
ALLERGIES: No Known Drug

Number: 401247
Age: 29
Sex: M
Room: 501
MR#: 897946562

VITAL SIGNS

05/18/04

MEDICATIONS

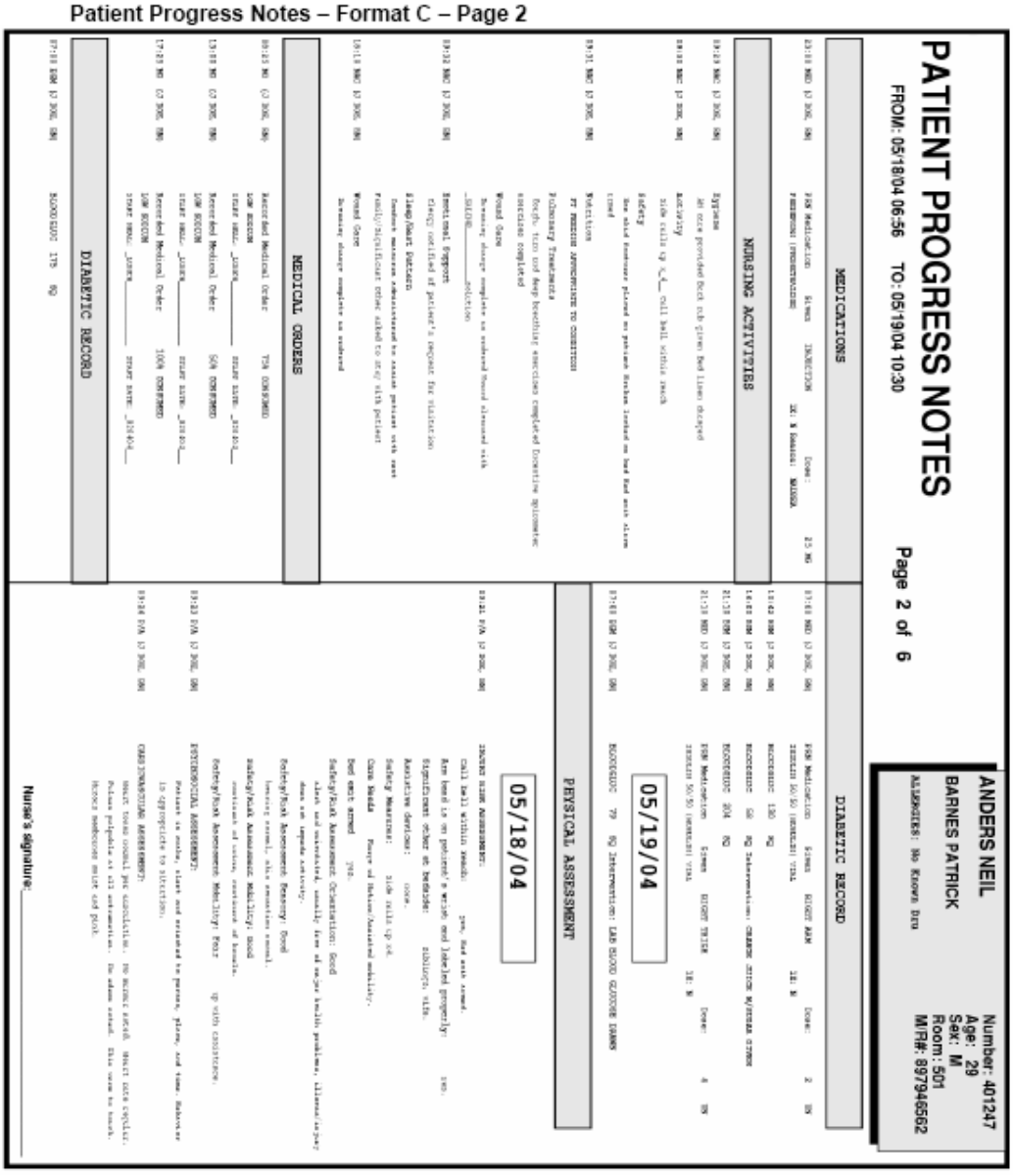
05/18/04

VITAL SIGNS

05/19/04

Nurse's signature:

Patient Progress Notes - Format C - Page 2



Patient Progress Notes – Format C – Page 2

PATIENT PROGRESS NOTES

FROM: 05/18/04 06:56 TO: 05/19/04 10:30

Page 2 of 6

ANDERS NEIL
BARNES PATRICK
ALLERGIES: No Known Drg

Number: 401247
Age: 29
Sex: M
Room: 501
MR#: 897946562

MEDICATIONS

DIABETIC RECORD

NURSING ACTIVITIES

MEDICAL ORDERS

PHYSICAL ASSESSMENT

05/18/04

05/19/04

DIABETIC RECORD

Nurse's signature:_____

Patient Progress Notes - Flow Chart Notes

Patient Progress Notes – Flow Chart Notes

PATIENT PROGRESS NOTES - Flow Chart Notes

From beginning of stay TO: 08/08/02 08:18 Page 2 of 2

BOLTZ CAROLYN
JAMES BAXTER, MD
ALLERGIES: Penicillin Codeine
AGE: 57
SEX: F
ROOM: 500
M/R#: 035309

ICU Flow Chart

08/07/02 04:00 {JRD, RN}
ABNORMAL H&H CALLED TO DR. SMITH. NO HEM ORDERS RECEIVED.

08/07/02 06:00 {JRD, RN}
PT. RESTING QUIETLY AND REMAINS STABLE. NO ACUTE PROBLEMS OTHER THAN ABNORMAL H&H WHICH WAS CALLED TO DR.SMITH AT 0400HRS.

PATIENT:	BOLTZ CAROLYN	NUMBER:	414455	AGE:	57	SEX:	F	ROOM:	500	PAGE:	2

Medication Charge Report

Medication Charge Report

MEDICATION CHARGE REPORT

FROM: 08/12/02 07:00 TO: 08/12/02 14:54

BOLTZ CAROLYN
JAMES BAXTER, MD
ALLERGIES: Penicillin Codeine

AGE: 55
SEX: F
ROOM: 501
M/R#: 035309

MEDICATIONS CHARGED

Order	Medication	Qty	Chg Amt	Adm by
4	PHENERGAN: 25 MG/ML	2.00	5.40	JRD
5	MILK OF MAGNESIA	2.00	3.96	JRD
7	ACETAM(ACETAMINOPHEN)TAB:325MG	2.00	2.50	JRD
8	AMOXICILLIN CAP : 250MG	1.00	1.25	JRD
10	DIFLUCAN (FLUCONAZOLE) TAB: 100MG	1.00	13.44	JRD
11	FAMOTIDINE TAB: 20 MG	1.00	5.00	JRD

PATIENT: BOLTZ CAROLYN NUMBER: 356959 AGE: 55 SEX: F ROOM: 501 PAGE: 1

Unisex Body Report

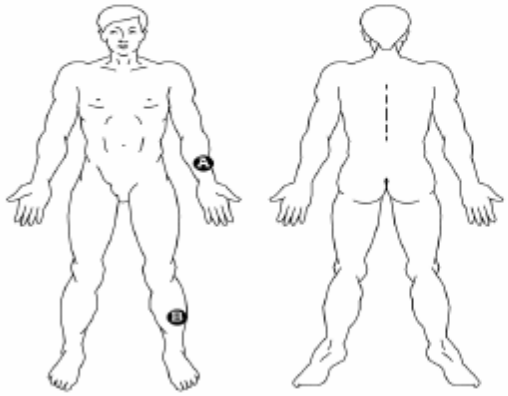
Unisex Body Report

356959 BOLTZ CAROLYN
Type of wound:

09/07/06 13:54 (JED, RN)

SITE A: Location: LT WRIST
Date First Observed: 09/07/06
Notes: 090706 0930 ORIF TO LT WRIST. FIBERGLASS CAST INTACT. NO EDEMA OR DRAINAGE NOTED.

SITE B: Location: LT ANKLE
Date First Observed: 09/07/06
Notes: 090706 0930 ORIF TO LT ANKLE. FIBERGLASS CAST INTACT. NO EDEMA OR DRAINAGE NOTED.



Stage I : The area is red in color with no breakdown of tissue.
Stage II : A partial thickness of skin is lost; may present as blistering surrounded by an area of redness and/or induration.
Stage III : A full thickness of skin is lost, exposing the subcutaneous tissues; presents as a shallow crater; may be draining.
Stage IV : A full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone; the sore may be covered with an eschar, draining, necrotic, reddened, and/or indurated.

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Displays patient's name, admitting physician, age, sex, room number, medical record number, and any drug allergies documented through the TruBridge EHR system. In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number, and page number will appear along the bottom edge of the page.

- **Entries:** Each entry will fall under the appropriate application heading. The heading will be highlighted with bold text and preceded by the following:
  - Time the entry was charted, if charting takes place over 2 days, the date and time associated with the charting will be included on the report if there is more than 24hrs between locks.
  - The name and title of the individual who entered the information
  - Two to three character code indicating the application in which the entry was charted

- **Application codes and descriptions:**
  - All routine medications that were administered or discontinued during the period covered by the report, if medications are selected to print on the Patient Progress Notes report. If a medication was administered using the second witness option, the system will print the second employee's initials and time of medication administration in a bold font underneath the first employee's initials and time of medication administration.
  - Medication description, dosage, frequency, & instructions, if medications are selected to print on the Patient Progress Notes report.
  - If an entry is made via the Notepad option on a flowchart, it will print on a separate page titled, PATIENT PROGRESS NOTES – Flow Chart Notes. This page will be the last page of the Patient Progress Notes.
  - Vital Signs: Body Mass Index (BMI) displays with Vital Signs each time Height/Weight are entered. BMI will re-calculate each time a new weight is entered. Height may remain constant. Mean Arterial Pressure (MAP) will calculate and display with the blood pressure documented.

(P/A)-Physical Assessment	(NSS)-Shift Summary	(PCA)-PCA Medications
(MED)-Pharmacy	(EDU)-Education	(VS)-Vital Signs
(NO)-Nursing Order	(BSU)-Diabetic Record	(ORD)-Ancillary Orders
(F/S)-Floor Stock	(NAC)-Nursing Activities	(PL)-Problem List

- **Signature Line:** An optional signature line is provided at the bottom of this report for the nurse primarily responsible for the patient's care. A switch located in the POC control record controls whether or not the signature line displays on the Patient Progress Notes.

- **Flow Chart Notes:** Flow Chart Notes prints with Patient Progress Notes. This report lists entries made via the notepad feature within a flowchart.

- **Medication Charge Report:** An optional Medication Charge report can print along with the Patient Progress Notes. This report is for nursing departments utilizing the Charge Meds at Administration feature. This report lists medications that will be charged when End-of-shift procedures are performed. A switch located in the POC control record controls whether or not the Medication Charge Report prints with the Patient Progress Notes.

- **Unisex Body Report:** An optional Unisex Body report can print along with the Patient Progress Notes. This report will only print if a physical assessment question has been answered that allowed documentation of a wound, pain, or decubitus location on the unisex body. This is not a cumulative report. It will list the marked sites (A-H) along with the site description(s). Also predefined Stage Descriptions will print at the bottom of the report. A switch located on the physical assessment questions controls whether or not the unisex body will display when the question is accessed.

- **Progress Note Format:** There are a choice of three formats set up in the chart cart control record. Format A will display vertically with entries in chronological order. Format B will display vertically grouped information based on what user has set up in the control record, in chronological order. Format C will display horizontally with entries in chronological order or in groups

NOTE: *Nursing Orders will now display a total of three lines of characters with 75 characters on each line for a total of 225 characters.*

Chapter 37 Patient Summary

The Patient Summary is a document that includes specific patient information charted within the previous 24 hours from the minute it is printed on the system. It can be printed at anytime during the patient's stay, but it is primarily printed at the end of each shift. The nursing staff can print the report, but the nurse assigned to the patient primarily prints it. Printing the Patient Summary is optional, unless otherwise specified by hospital policy. The report is usually not a permanent part of the patient's chart and can be discarded after use.

37.1 How to Print

The Patient Summary Report may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart select the appropriate tab.
3. Select **Patient Summary Report**.
4. Select a patient by choosing "This Department", "My Patients", or "Current Patients."
5. Click patient name and then "Add Selected" to add patient to Patient Selection List
6. Select **Process**.

   System prompts "Enter Number of Copies to Print"
7. Enter the number of reports to print.
8. Select **OK.**

Q. WHAT ARE THE SETUP OPTIONS FOR PRINTING?
A. The Patient Summary can be set up to print:

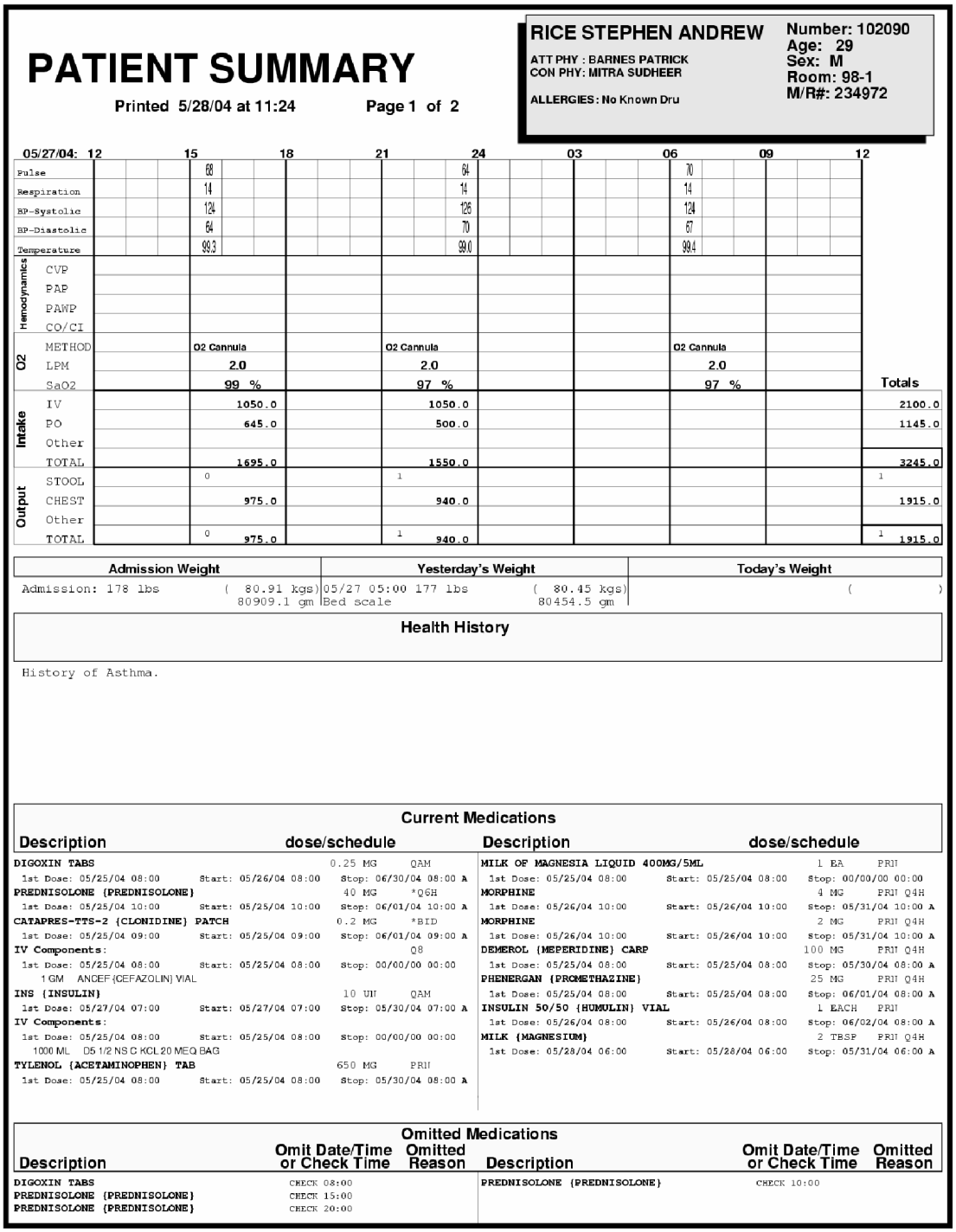
- as part of end-of-shift reports
- as part of discharge reports and designated for multiple copies
- to automatically print at a specific hour to a specific printer.
- Last action taken to problem: evaluation, intervention, addressed, resolved, etc.

The code for this report is "PS," which is set up in the Point of Care Department Table through Nursing Administration, Hospital Base Menu-Master Selection-B-1-N.

37.2 Description and Usage

The Patient Summary is a document that includes specific patient information charted within the previous 24 hours from the minute it is printed on the system. This worksheet provides both nurses and physicians details of the patient's condition and plan of care. It is the primary tool used by nursing to conduct an organized and timely shift change. It is one of the reports preferred by physicians to use as a reference while making rounds.

Patient Summary – Format A – Page 1



PATIENT SUMMARY

Printed 5/28/04 at 11:24 Page 1 of 2

RICE STEPHEN ANDREW Number: 102090
Age: 29
Sex: M
Room: 98-1
M/R#: 234972

ATT PHY : BARNES PATRICK
CON PHY: MITRA SUDHEER

ALLERGIES: No Known Dru

05/27/04: 12	15	18	21	24	03	06	09	12	
Pulse	68			64		70			
Respiration	14			14		14			
BP-Systolic	124			126		124			
BP-Diastolic	64			70		67			
Temperature	99.3			99.0		99.4			
Hemodynamics CVP									
Hemodynamics PAP									
Hemodynamics PAWP									
Hemodynamics CO/CI									
O2 METHOD	O2 Cannula			O2 Cannula		O2 Cannula			
O2 LPM	2.0			2.0		2.0			
O2 SaO2	99 %			97 %		97 %			Totals
Intake IV	1050.0			1050.0					2100.0
Intake PO	645.0			500.0					1145.0
Intake Other									
Intake TOTAL	1695.0			1550.0					3245.0
Output STOOL	0			1					1
Output CHEST	975.0			940.0					1915.0
Output Other									
Output TOTAL	0 975.0			1 940.0					1 1915.0

Admission Weight	Yesterday's Weight	Today's Weight
Admission: 178 lbs (80.91 kgs) 80909.1 gm	05/27 05:00 177 lbs (80.45 kgs) Bed scale 80454.5 gm	( )

Health History

History of Asthma.

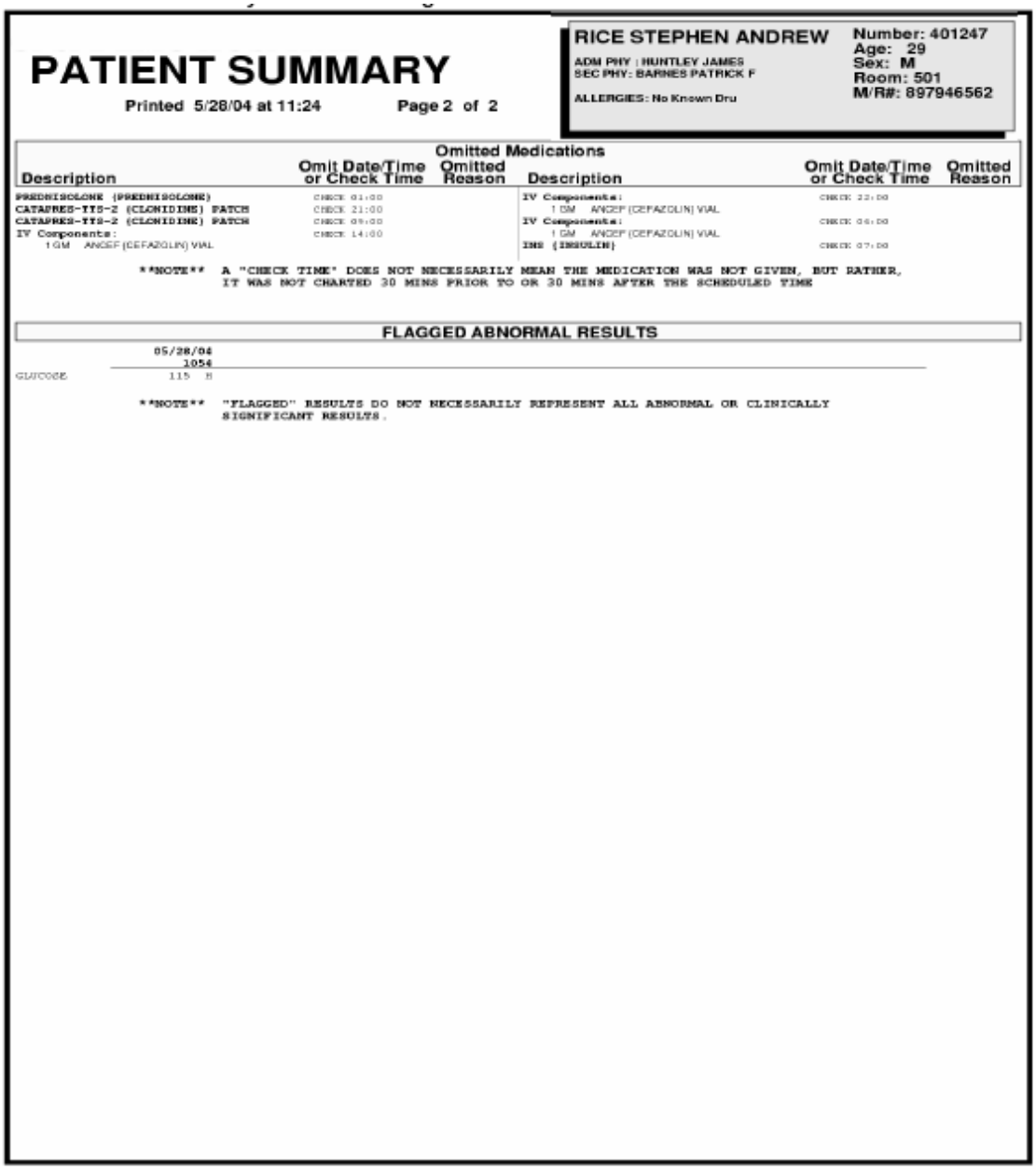
Current Medications

Description	dose/schedule	Description	dose/schedule
DIGOXIN TABS	0.25 MG QAM	MILK OF MAGNESIA LIQUID 400MG/5ML	1 EA PRN
1st Dose: 05/25/04 08:00 Start: 05/26/04 08:00 Stop: 06/30/04 08:00 A		1st Dose: 05/25/04 08:00 Start: 05/25/04 08:00 Stop: 00/00/00 00:00	
PREDNISOLONE (PREDNISOLONE)	40 MG *Q6H	MORPHINE	4 MG PRN Q4H
1st Dose: 05/25/04 10:00 Start: 05/25/04 10:00 Stop: 06/01/04 10:00 A		1st Dose: 05/26/04 10:00 Start: 05/26/04 10:00 Stop: 05/31/04 10:00 A	
CATAPRES-TTS-2 (CLONIDINE) PATCH	0.2 MG *BID	MORPHINE	2 MG PRN Q4H
1st Dose: 05/25/04 09:00 Start: 05/25/04 09:00 Stop: 06/01/04 09:00 A		1st Dose: 05/26/04 10:00 Start: 05/26/04 10:00 Stop: 05/31/04 10:00 A	
IV Components:	Q8	DEMEROL (MEPERIDINE) CARP	100 MG PRN Q4H
1st Dose: 05/25/04 08:00 Start: 05/25/04 08:00 Stop: 00/00/00 00:00		1st Dose: 05/25/04 08:00 Start: 05/25/04 08:00 Stop: 05/30/04 08:00 A	
1 GM ANCEF (CEFAZOLIN) VIAL		PHENERGAN (PROMETHAZINE)	25 MG PRN Q4H
INS (INSULIN)	10 UN QAM	1st Dose: 05/25/04 08:00 Start: 05/25/04 08:00 Stop: 06/01/04 08:00 A	
1st Dose: 05/27/04 07:00 Start: 05/27/04 07:00 Stop: 05/30/04 07:00 A		INSULIN 50/50 (HUMULIN) VIAL	1 EACH PRN
IV Components:		1st Dose: 05/26/04 08:00 Start: 05/26/04 08:00 Stop: 06/02/04 08:00 A	
1st Dose: 05/25/04 08:00 Start: 05/25/04 08:00 Stop: 00/00/00 00:00		MILK (MAGNESIUM)	2 TBSP PRN Q4H
1000 ML D5 1/2 NS C KCL 20 MEQ BAG		1st Dose: 05/28/04 06:00 Start: 05/28/04 06:00 Stop: 05/31/04 06:00 A	
TYLENOL (ACETAMINOPHEN) TAB	650 MG PRN		
1st Dose: 05/25/04 08:00 Start: 05/25/04 08:00 Stop: 05/30/04 08:00 A			

Omitted Medications

Description	Omit Date/Time or Check Time	Omitted Reason	Description	Omit Date/Time or Check Time	Omitted Reason
DIGOXIN TABS	CHECK 08:00		PREDNISOLONE (PREDNISOLONE)	CHECK 10:00	
PREDNISOLONE (PREDNISOLONE)	CHECK 15:00				
PREDNISOLONE (PREDNISOLONE)	CHECK 20:00				

Patient Summary – Format A- Page 2



PATIENT SUMMARY

Printed 5/28/04 at 11:24 Page 2 of 2

RICE STEPHEN ANDREW
ADM PHY : HUNTLEY JAMES
SEC PHY: BARNES PATRICK F
ALLERGIES: No Known Dru

Number: 401247
Age: 29
Sex: M
Room: 501
M/R#: 897946562

Omitted Medications

Description	Omit Date/Time or Check Time	Omitted Reason	Description	Omit Date/Time or Check Time	Omitted Reason
PREDNISOLONE (PREDNISOLONE)	CHECK 01:00		IV Components:	CHECK 22:00	
CATAPRES-TTS-2 (CLONIDINE) PATCH	CHECK 21:00		1 GM ANCEF (CEFAZOLIN) VIAL		
CATAPRES-TTS-2 (CLONIDINE) PATCH	CHECK 09:00		IV Components:	CHECK 06:00	
IV Components:	CHECK 14:00		1 GM ANCEF (CEFAZOLIN) VIAL		
1 GM ANCEF (CEFAZOLIN) VIAL			INS (INSULIN)	CHECK 07:00	

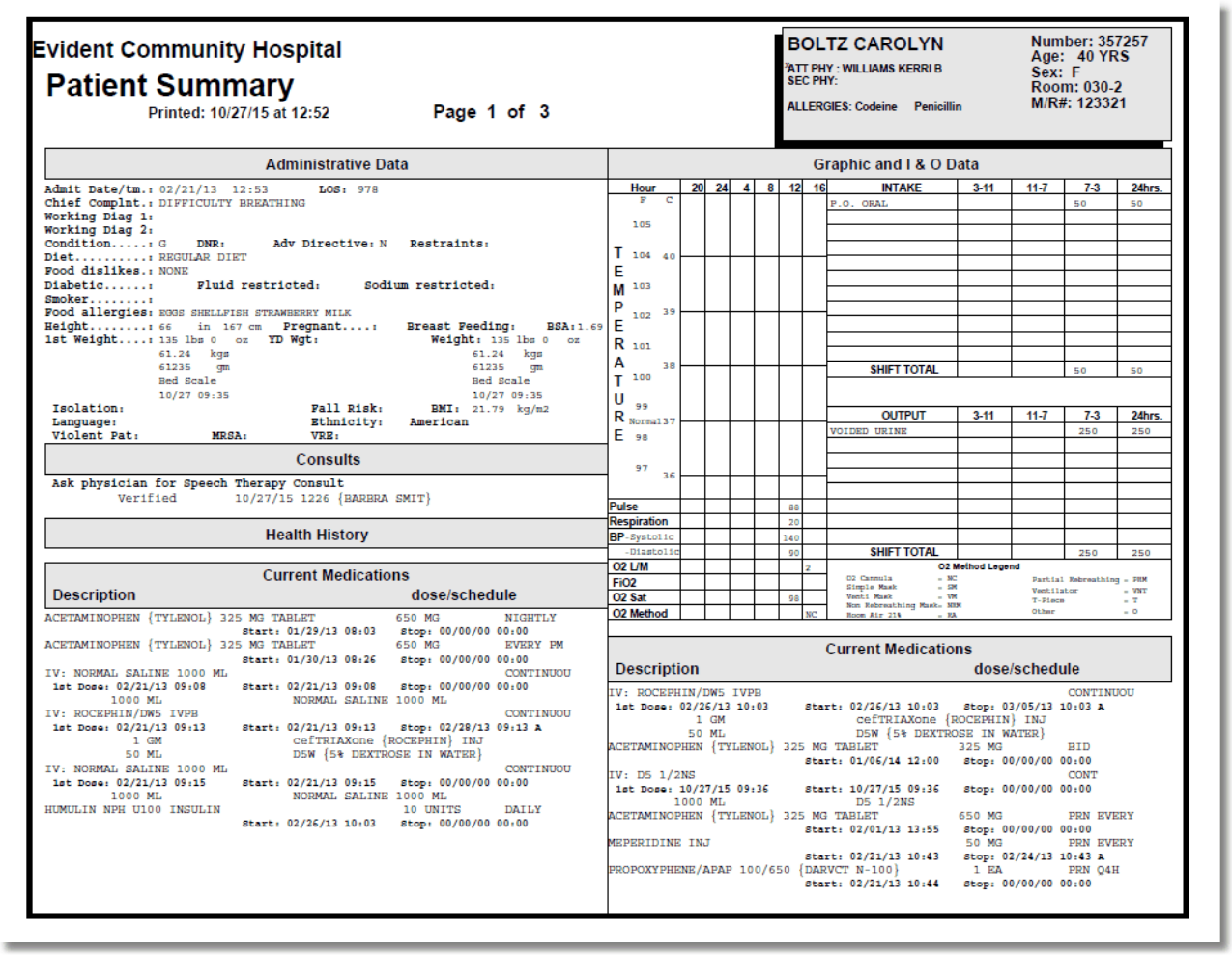
NOTE A "CHECK TIME" DOES NOT NECESSARILY MEAN THE MEDICATION WAS NOT GIVEN, BUT RATHER, IT WAS NOT CHARTED 30 MINS PRIOR TO OR 30 MINS AFTER THE SCHEDULED TIME

FLAGGED ABNORMAL RESULTS

	05/28/04 1054	
GLUCOSE	115 H	

NOTE "FLAGGED" RESULTS DO NOT NECESSARILY REPRESENT ALL ABNORMAL OR CLINICALLY SIGNIFICANT RESULTS.

Patient Summary - Format B - Page 1



Evident Community Hospital

Patient Summary

Printed: 10/27/15 at 12:52 Page 1 of 3

BOLTZ CAROLYN
ATT PHY : WILLIAMS KERRI B
SEC PHY:
ALLERGIES: Codeine Penicillin

Number: 357257
Age: 40 YRS
Sex: F
Room: 030-2
M/R#: 123321

Administrative Data

Admit Date/tm.: 02/21/13 12:53 LOS: 978
Chief Complnt.: DIFFICULTY BREATHING
Working Diag 1:
Working Diag 2:
Condition.....: G DNR: Adv Directive: N Restraints:
Diet.....: REGULAR DIET
Food dislikes.: NONE
Diabetic.....: Fluid restricted: Sodium restricted:
Smoker.....:
Food allergies: EGGS SHELLFISH STRAWBERRY MILK
Height.....: 66 in 167 cm Pregnant....: Breast Feeding: BSA:1.69
1st Weight....: 135 lbs 0 oz YD Wgt: Weight: 135 lbs 0 oz
61.24 kgs 61.24 kgs
61235 gm 61235 gm
Bed Scale Bed Scale
10/27 09:35 10/27 09:35
Isolation: Fall Risk: BMI: 21.79 kg/m2
Language: Ethnicity: American
Violent Pat: MRSA: VRE:

Consults

Ask physician for Speech Therapy Consult
Verified 10/27/15 1226 {BARBRA SMIT}

Health History

Current Medications

Description	dose/schedule
ACETAMINOPHEN {TYLENOL} 325 MG TABLET	650 MG NIGHTLY
	Start: 01/29/13 08:03 Stop: 00/00/00 00:00
ACETAMINOPHEN {TYLENOL} 325 MG TABLET	650 MG EVERY PM
	Start: 01/30/13 08:26 Stop: 00/00/00 00:00
IV: NORMAL SALINE 1000 ML	CONTINUOU
1st Dose: 02/21/13 09:08	Start: 02/21/13 09:08 Stop: 00/00/00 00:00
1000 ML	NORMAL SALINE 1000 ML
IV: ROCEPHIN/DW5 IVPB	CONTINUOU
1st Dose: 02/21/13 09:13	Start: 02/21/13 09:13 Stop: 02/28/13 09:13 A
1 GM	ceftRIAXone {ROCEPHIN} INJ
50 ML	D5W {5% DEXTROSE IN WATER}
IV: NORMAL SALINE 1000 ML	CONTINUOU
1st Dose: 02/21/13 09:15	Start: 02/21/13 09:15 Stop: 00/00/00 00:00
1000 ML	NORMAL SALINE 1000 ML
HUMULIN NPH U100 INSULIN	10 UNITS DAILY
	Start: 02/26/13 10:03 Stop: 00/00/00 00:00

Graphic and I & O Data

Hour	20	24	4	8	12	16
TEMPERATURE F / C						
105						
104 / 40						
103						
102 / 39						
101						
100 / 38						
99						
Normal 98.7 / 37						
98						
97 / 36						
Pulse					88	
Respiration					20	
BP - Systolic					140	
- Diastolic					90	
O2 L/M						2
FiO2						
O2 Sat					98	
O2 Method						NC

INTAKE	3-11	11-7	7-3	24hrs.
P.O. ORAL			50	50
SHIFT TOTAL			50	50

OUTPUT	3-11	11-7	7-3	24hrs.
VOIDED URINE			250	250
SHIFT TOTAL			250	250

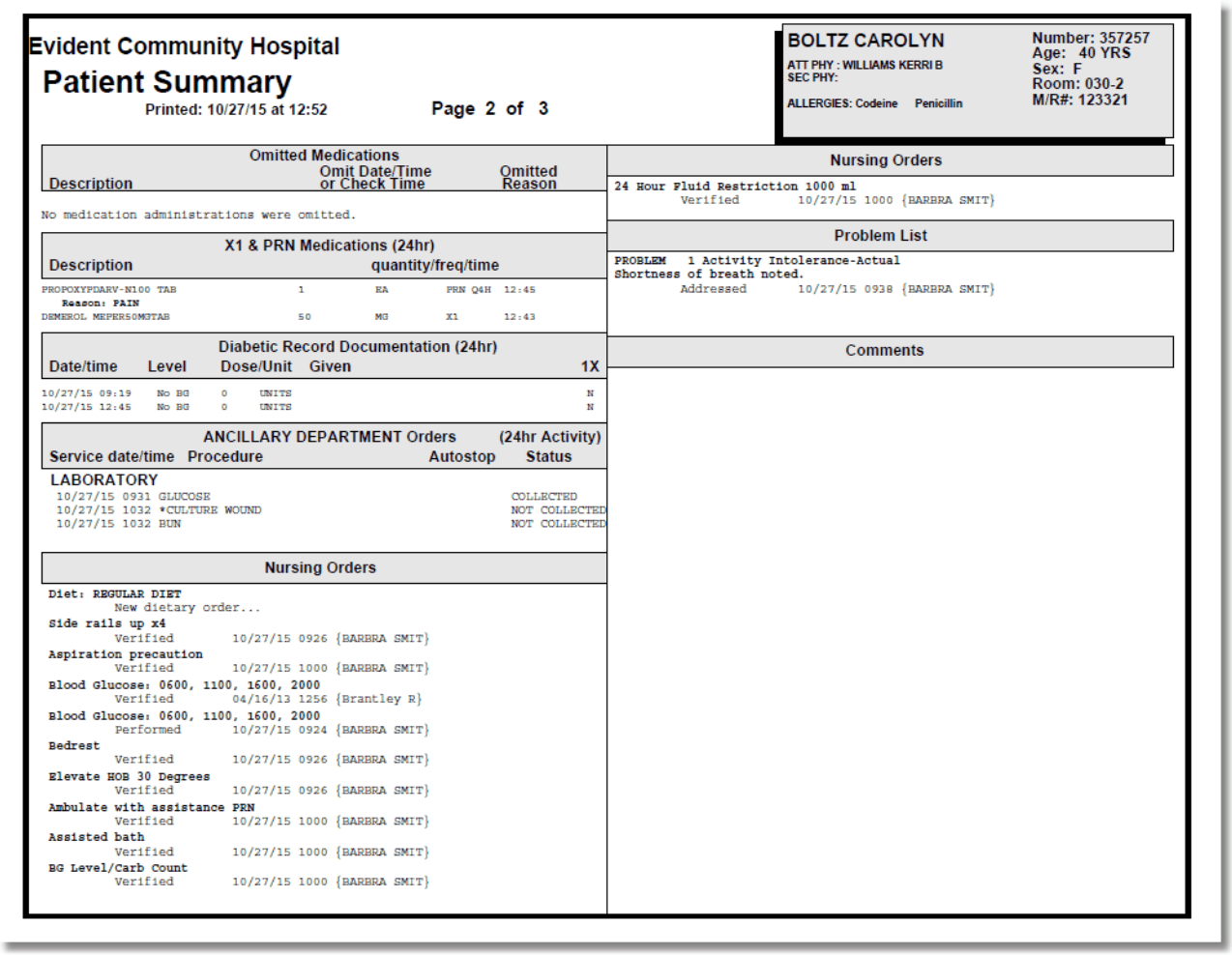
O2 Method Legend

O2 Cannula	= NC	Partial Rebreathing	= PRM
Simple Mask	= SM	Ventilator	= VNT
Venti Mask	= VM	T-Piece	= T
Non Rebreathing Mask	= NRM	Other	= O
Room Air 21%	= RA		

Current Medications

Description	dose/schedule
IV: ROCEPHIN/DW5 IVPB	CONTINUOU
1st Dose: 02/26/13 10:03	Start: 02/26/13 10:03 Stop: 03/05/13 10:03 A
1 GM	ceftRIAXone {ROCEPHIN} INJ
50 ML	D5W {5% DEXTROSE IN WATER}
ACETAMINOPHEN {TYLENOL} 325 MG TABLET	325 MG BID
	Start: 01/06/14 12:00 Stop: 00/00/00 00:00
IV: D5 1/2NS	CONT
1st Dose: 10/27/15 09:36	Start: 10/27/15 09:36 Stop: 00/00/00 00:00
1000 ML	D5 1/2NS
ACETAMINOPHEN {TYLENOL} 325 MG TABLET	650 MG PRN EVERY
	Start: 02/01/13 13:55 Stop: 00/00/00 00:00
MEPERIDINE INJ	50 MG PRN EVERY
	Start: 02/21/13 10:43 Stop: 02/24/13 10:43 A
PROPOXYPHENE/APAP 100/650 {DARVCT N-100}	1 EA PRN Q4H
	Start: 02/21/13 10:44 Stop: 00/00/00 00:00

Patient Summary - Format B - Page 2



Evident Community Hospital

Patient Summary

Printed: 10/27/15 at 12:52 Page 2 of 3

BOLTZ CAROLYN
ATT PHY : WILLIAMS KERRI B
SEC PHY:
ALLERGIES: Codeine Penicillin

Number: 357257
Age: 40 YRS
Sex: F
Room: 030-2
M/R#: 123321

Omitted Medications

Description	Omit Date/Time or Check Time	Omitted Reason

No medication administrations were omitted.

X1 & PRN Medications (24hr)

Description	quantity/freq/time
PROPOXYPDARV-N100 TAB	1 EA PRN Q4H 12:45
Reason: PAIN	
DEMEROL MEPER50MGTAB	50 MG X1 12:43

Diabetic Record Documentation (24hr)

Date/time	Level	Dose/Unit	Given	1X
10/27/15 09:19	No BG	0 UNITS		N
10/27/15 12:45	No BG	0 UNITS		N

ANCILLARY DEPARTMENT Orders (24hr Activity)

Service date/time	Procedure	Autostop	Status
LABORATORY			
10/27/15 0931	GLUCOSE		COLLECTED
10/27/15 1032	*CULTURE WOUND		NOT COLLECTED
10/27/15 1032	BUN		NOT COLLECTED

Nursing Orders

Diet: REGULAR DIET
New dietary order...
Side rails up x4
Verified 10/27/15 0926 {BARBRA SMIT}
Aspiration precaution
Verified 10/27/15 1000 {BARBRA SMIT}
Blood Glucose: 0600, 1100, 1600, 2000
Verified 04/16/13 1256 {Brantley R}
Blood Glucose: 0600, 1100, 1600, 2000
Performed 10/27/15 0924 {BARBRA SMIT}
Bedrest
Verified 10/27/15 0926 {BARBRA SMIT}
Elevate HOB 30 Degrees
Verified 10/27/15 0926 {BARBRA SMIT}
Ambulate with assistance PRN
Verified 10/27/15 1000 {BARBRA SMIT}
Assisted bath
Verified 10/27/15 1000 {BARBRA SMIT}
BG Level/Carb Count
Verified 10/27/15 1000 {BARBRA SMIT}

Nursing Orders

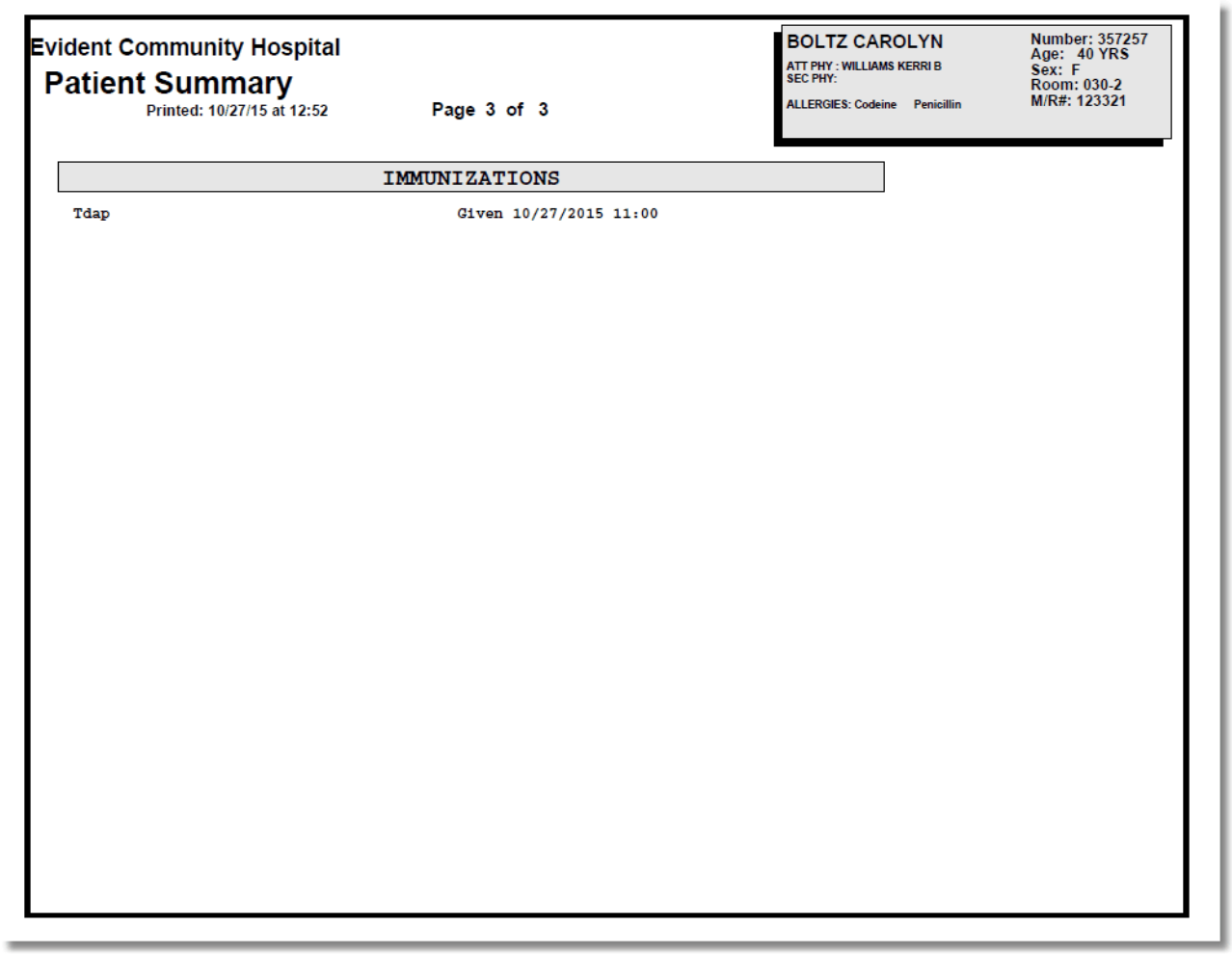
24 Hour Fluid Restriction 1000 ml
Verified 10/27/15 1000 {BARBRA SMIT}

Problem List

PROBLEM 1 Activity Intolerance-Actual
Shortness of breath noted.
Addressed 10/27/15 0938 {BARBRA SMIT}

Comments

Patient Summary - Format B - Page 3



Evident Community Hospital

Patient Summary

Printed: 10/27/15 at 12:52 Page 3 of 3

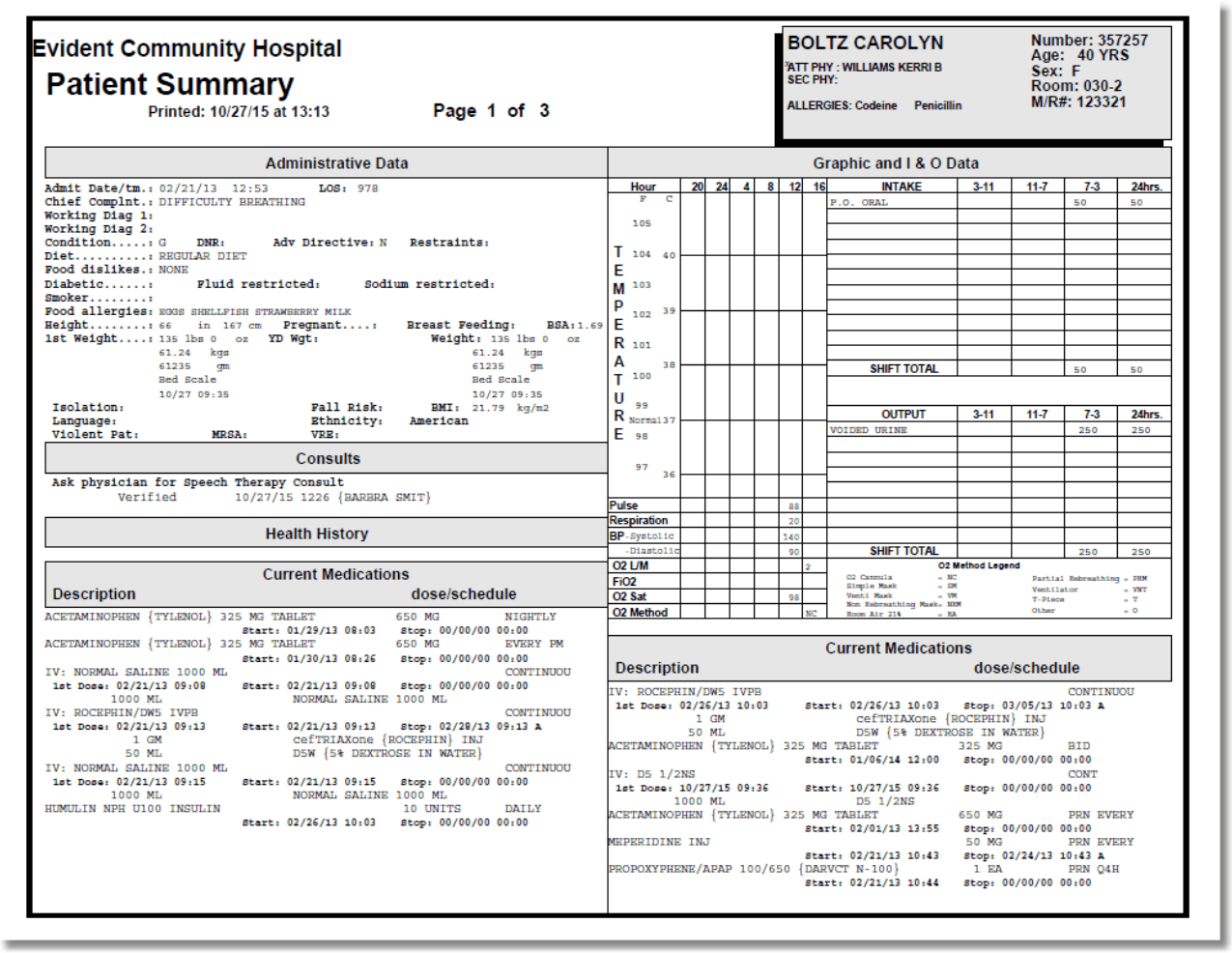
BOLTZ CAROLYN
ATT PHY : WILLIAMS KERRI B
SEC PHY:
ALLERGIES: Codeine Penicillin

Number: 357257
Age: 40 YRS
Sex: F
Room: 030-2
M/R#: 123321

IMMUNIZATIONS

Tdap Given 10/27/2015 11:00

Patient Summary - Format C - Page 1



Evident Community Hospital

Patient Summary

Printed: 10/27/15 at 13:13 Page 1 of 3

BOLTZ CAROLYN Number: 357257
ATT PHY : WILLIAMS KERRI B Age: 40 YRS
SEC PHY: Sex: F
Room: 030-2
ALLERGIES: Codeine Penicillin M/R#: 123321

Administrative Data

Admit Date/tm.: 02/21/13 12:53 LOS: 978
Chief Complnt.: DIFFICULTY BREATHING
Working Diag 1:
Working Diag 2:
Condition.....: G DNR: Adv Directive: N Restraints:
Diet.....: REGULAR DIET
Food dislikes.: NONE
Diabetic.....: Fluid restricted: Sodium restricted:
Smoker.....:
Food allergies: EGGS SHELLFISH STRAWBERRY MILK
Height.....: 66 in 167 cm Pregnant....: Breast Feeding: BSA:1.69
1st Weight....: 135 lbs 0 oz YD Wgt: Weight: 135 lbs 0 oz
61.24 kgs 61.24 kgs
61235 gm 61235 gm
Bed Scale Bed Scale
10/27 09:35 10/27 09:35
Isolation: Fall Risk: BMI: 21.79 kg/m2
Language: Ethnicity: American
Violent Pat: MRSA: VRE:

Consults

Ask physician for Speech Therapy Consult
Verified 10/27/15 1226 {BARBRA SMIT}

Health History

Current Medications

Description	dose/schedule
ACETAMINOPHEN {TYLENOL} 325 MG TABLET	650 MG NIGHTLY
	Start: 01/29/13 08:03 Stop: 00/00/00 00:00
ACETAMINOPHEN {TYLENOL} 325 MG TABLET	650 MG EVERY PM
	Start: 01/30/13 08:26 Stop: 00/00/00 00:00
IV: NORMAL SALINE 1000 ML	CONTINUOU
1st Dose: 02/21/13 09:08	Start: 02/21/13 09:08 Stop: 00/00/00 00:00
1000 ML	NORMAL SALINE 1000 ML
IV: ROCEPHIN/DW5 IVPB	CONTINUOU
1st Dose: 02/21/13 09:13	Start: 02/21/13 09:13 Stop: 02/28/13 09:13 A
1 GM	cefTRIAXone {ROCEPHIN} INJ
50 ML	D5W {5% DEXTROSE IN WATER}
IV: NORMAL SALINE 1000 ML	CONTINUOU
1st Dose: 02/21/13 09:15	Start: 02/21/13 09:15 Stop: 00/00/00 00:00
1000 ML	NORMAL SALINE 1000 ML
HUMULIN NPH U100 INSULIN	10 UNITS DAILY
	Start: 02/26/13 10:03 Stop: 00/00/00 00:00

Graphic and I & O Data

Hour	20	24	4	8	12	16
TEMPERATURE F / C (105 / 40.5, 104 / 40, 103, 102 / 39, 101, 100 / 38, 99 Normal 37, 98, 97 / 36)						
Pulse					88	
Respiration					20	
BP - Systolic					140	
BP - Diastolic					90	
O2 L/M						2
FiO2						
O2 Sat					98	
O2 Method						NC

INTAKE	3-11	11-7	7-3	24hrs.
P.O. ORAL			50	50
SHIFT TOTAL			50	50

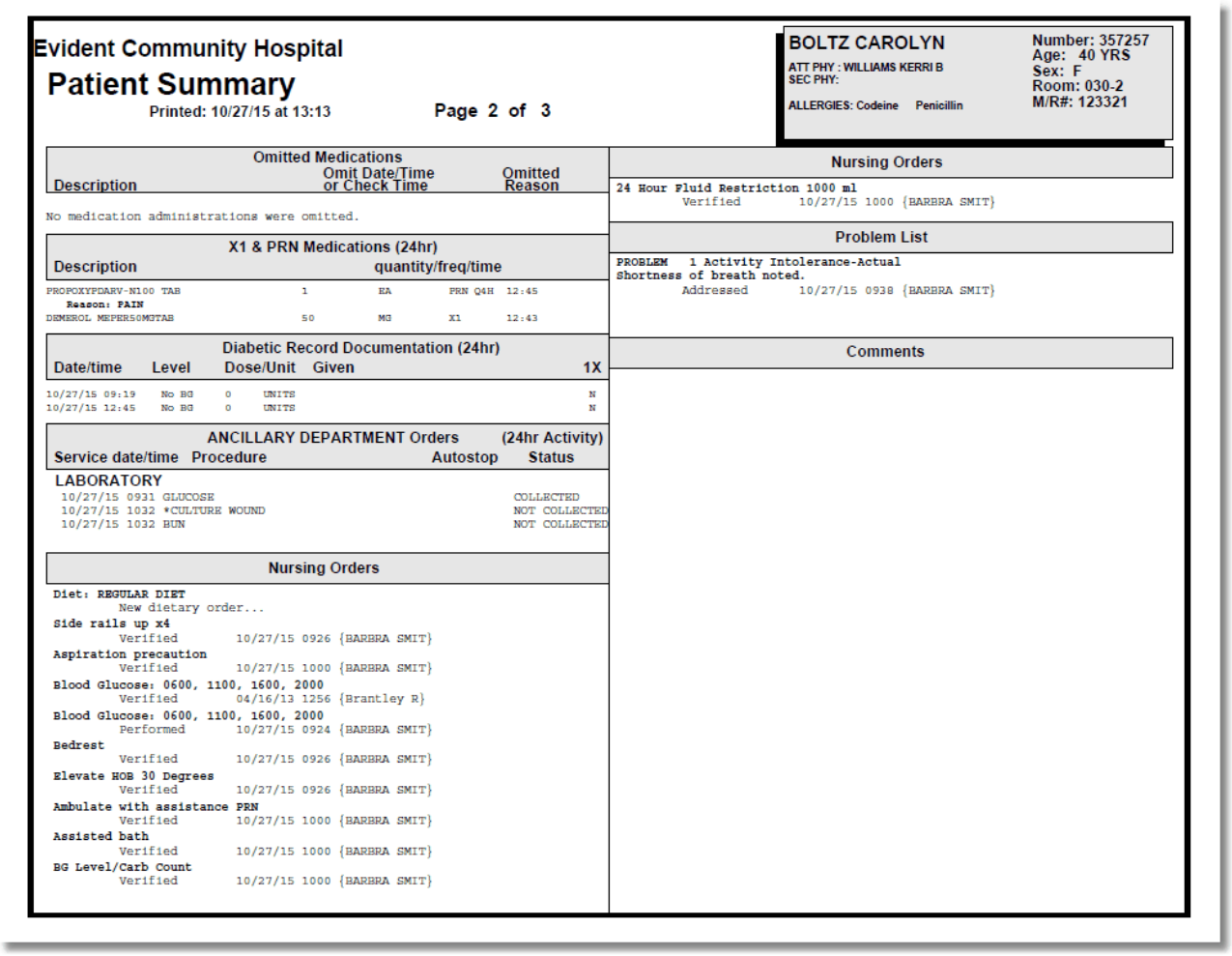
OUTPUT	3-11	11-7	7-3	24hrs.
VOIDED URINE			250	250
SHIFT TOTAL			250	250

O2 Method Legend
O2 Cannula = NC
Simple Mask = SM
Venti Mask = VM
Non Rebreathing Mask = NRM
Room Air 21% = RA
Partial Rebreathing = PRM
Ventilator = VNT
T-Piece = T
Other = O

Current Medications

Description	dose/schedule
IV: ROCEPHIN/DW5 IVPB	CONTINUOU
1st Dose: 02/26/13 10:03	Start: 02/26/13 10:03 Stop: 03/05/13 10:03 A
1 GM	cefTRIAXone {ROCEPHIN} INJ
50 ML	D5W {5% DEXTROSE IN WATER}
ACETAMINOPHEN {TYLENOL} 325 MG TABLET	325 MG BID
	Start: 01/06/14 12:00 Stop: 00/00/00 00:00
IV: D5 1/2NS	CONT
1st Dose: 10/27/15 09:36	Start: 10/27/15 09:36 Stop: 00/00/00 00:00
1000 ML	D5 1/2NS
ACETAMINOPHEN {TYLENOL} 325 MG TABLET	650 MG PRN EVERY
	Start: 02/01/13 13:55 Stop: 00/00/00 00:00
MEPERIDINE INJ	50 MG PRN EVERY
	Start: 02/21/13 10:43 Stop: 02/24/13 10:43 A
PROPOXYPHENE/APAP 100/650 {DARVCT N-100}	1 EA PRN Q4H
	Start: 02/21/13 10:44 Stop: 00/00/00 00:00

Patient Summary - Format C - Page 2



Evident Community Hospital

Patient Summary

Printed: 10/27/15 at 13:13 Page 2 of 3

BOLTZ CAROLYN
ATT PHY : WILLIAMS KERRI B
SEC PHY:
ALLERGIES: Codeine Penicillin

Number: 357257
Age: 40 YRS
Sex: F
Room: 030-2
M/R#: 123321

Omitted Medications

Description	Omit Date/Time or Check Time	Omitted Reason

No medication administrations were omitted.

X1 & PRN Medications (24hr)

Description	quantity/freq/time			
PROPOXYPDARV-N100 TAB	1	EA	PRN Q4H	12:45
Reason: PAIN				
DEMEROL MEPERS0MGTAB	50	MG	X1	12:43

Diabetic Record Documentation (24hr)

Date/time	Level	Dose/Unit	Given	1X
10/27/15 09:19	No BG	0 UNITS		N
10/27/15 12:45	No BG	0 UNITS		N

ANCILLARY DEPARTMENT Orders (24hr Activity)

Service date/time	Procedure	Autostop	Status
LABORATORY			
10/27/15 0931	GLUCOSE		COLLECTED
10/27/15 1032	*CULTURE WOUND		NOT COLLECTED
10/27/15 1032	BUN		NOT COLLECTED

Nursing Orders

Diet: REGULAR DIET
New dietary order...
Side rails up x4
Verified 10/27/15 0926 {BARBRA SMIT}
Aspiration precaution
Verified 10/27/15 1000 {BARBRA SMIT}
Blood Glucose: 0600, 1100, 1600, 2000
Verified 04/16/13 1256 {Brantley R}
Blood Glucose: 0600, 1100, 1600, 2000
Performed 10/27/15 0924 {BARBRA SMIT}
Bedrest
Verified 10/27/15 0926 {BARBRA SMIT}
Elevate HOB 30 Degrees
Verified 10/27/15 0926 {BARBRA SMIT}
Ambulate with assistance PRN
Verified 10/27/15 1000 {BARBRA SMIT}
Assisted bath
Verified 10/27/15 1000 {BARBRA SMIT}
BG Level/Carb Count
Verified 10/27/15 1000 {BARBRA SMIT}

Nursing Orders

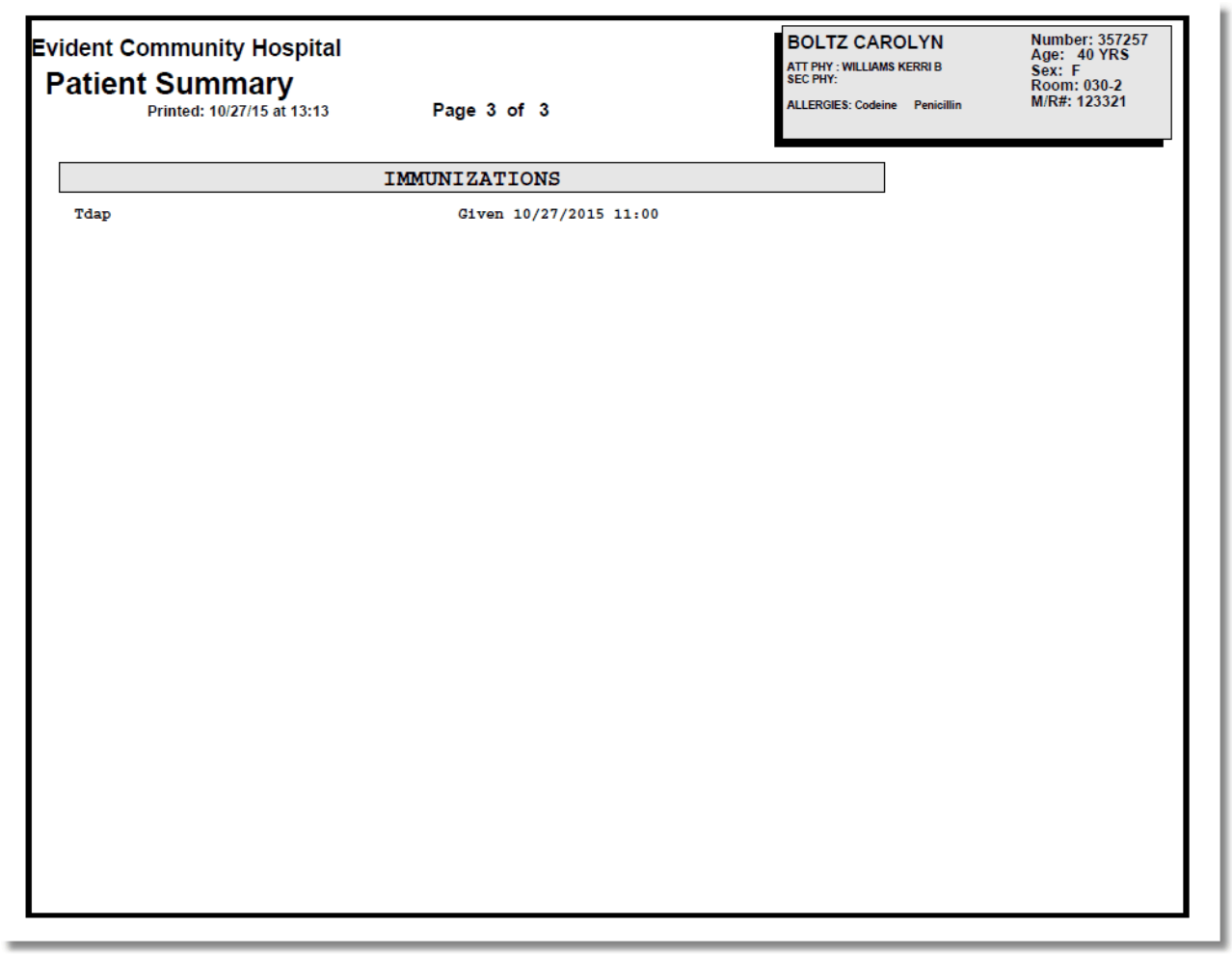
24 Hour Fluid Restriction 1000 ml
Verified 10/27/15 1000 {BARBRA SMIT}

Problem List

PROBLEM 1 Activity Intolerance-Actual
Shortness of breath noted.
Addressed 10/27/15 0938 {BARBRA SMIT}

Comments

Patient Summary - Format C - Page 3



Evident Community Hospital

Patient Summary

Printed: 10/27/15 at 13:13 Page 3 of 3

BOLTZ CAROLYN
ATT PHY : WILLIAMS KERRI B
SEC PHY:
ALLERGIES: Codeine Penicillin

Number: 357257
Age: 40 YRS
Sex: F
Room: 030-2
M/R#: 123321

IMMUNIZATIONS

Tdap Given 10/27/2015 11:00

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Displays patient's name, patient account number, admitting and second physician, age, sex, room number, medical record number, and any drug allergies documented through the TruBridge EHR system.
- **Administrative Data:** Displays admission date and time, length of stay, chief complaint, working diagnoses 1 and 2, current diet, food dislikes, food allergies, and indicators of diabetic status, fluid restriction, sodium restriction, smoker status, height in inches and centimeters, if patient is pregnant or breastfeeding, 1st weight, yesterday's weight and current weight in pounds and kilograms, admitting condition and body surface area, isolation, fall risk, language, and ethnicity.
- **Consults (Optional):** Displays the description of the consultation and the status of the consultation. In order for this information to be reflected, it must be set up by Nursing Administration.
- **Health History:** Includes patient's health history entered via the Initial Interview.

- **Current Medications:** Lists all active medications at the time the report is printed. Can include future dated medication orders. This feature is controlled by a switch in the Patient Summary setup. Can also include medication description, dose, frequency, and auto stop date if applicable. Does not include discontinued medications

- **X1 (one-time) and PRN Medications:** Includes all X1 & PRN administrations in the previous 24 hour period as well as the medication description, quantity, frequency and time of administration. Will also include a reason on PRN medications. It does not include discontinued medications.

- **Omitted Medications:** Includes all omitted medications in the previous 24 hour period as well as the date and time and reason for omission. Also includes "Check" time medications: if a medication is administered outside of the 30 minute window prior to or after administration time, the system can be set to flag the administration with "Check". This feature is controlled by a switch in the Point of Care Control Record in the Nursing Administration Department.

- **Accucheck Readings: (blood glucose monitoring):** Includes all administrations in the previous 24 hour period, date and time entry was charted, blood sugar level, description of medication given (sliding scale insulin only), unit(s) of medication given, frequency, and any other interventions charted.

- **Graphic and I/O Data:** Graph displays the twenty-four hours in four hour intervals. The temperature is reflected in a line graph format. Pulse, respiration, blood pressure, O2, O2 L/Min, FiO2, and O2 Sat values display below the graph. The intake and output volumes reflect totals per shift, and a twenty-four hour total. I&O entries charted by frequency, display in the top left corner of the boxes where volume entries also display. Nursery intake options will include P.O. Formula, Pedialyte, Sterile Water, 5% Glucose Water, and Breast Feeding time, minutes, and breast side. Nursery output option will include wet diapers. Pediatric intake options will include P.O. Formula, PO Baby Food, PO Pedialyte and Breast Feeding time, minutes, and breast side.

NOTE: *An asterisk (*) adjacent to pulse, respiration, and blood pressure, denotes multiple values have been charted. The most current recorded value displays, with previous values listed in the Patient Progress Notes.*

- **IV Fluid Left to Count/Drainage Level (Optional):** Displays IV and IV Piggy administrations in the previous 24 hour period, IV fluid left to count and flow rate, drainage level, and date and time last charted. In order for this information to be reflected, it must be set up by Nursing Administration.

- **Ancillary Department Orders:** Displays the type of service (Radiology, Laboratory, Respiratory Care, EKG/EEG, and Physical Therapy), date and time the order was entered, description of the procedure, and status of the order (including future scheduled order times, orders completed, and orders discontinued). Orders that have been completed for more than 24 hours will not print in this section.

- **Nursing Orders:** Displays description of the order, status of the order (performed, completed, discontinued, etc.), date and time the order was addressed, and the name and title of the person who charted the entry. Any comments charted in reference to the order. Nursing order description fields have been expanded to include up to three lines of 75 characters on each line (225 characters total). This displays on Formats B and C.

- **Problem List:** Displays the description of problem and rank date and time of the last action taken and the name and title of the person who charted the entry. Any comments charted in reference to the problem.

- **Distinctive Nursing Assessments (Optional):** Displays assessments charted in the last eight hours that have been deemed as distinctive and should be noted by the nursing staff. In order for this information to be reflected, it must be set up by Nursing Administration.

- **Comments:** An area for nursing to make any additional handwritten comments regarding the patient, to pass along to the on-coming nurse during shift report

- **Immunizations:** Lists immunizations and the dates they were received

Chapter 38 PCA Infusion Form

The PCA Infusion Form is a cumulative document that includes the patient's PCA administration chart and assessment from the beginning of stay. It can be printed at anytime during the patient's stay, but should be printed at the end of each shift or automatically at a specific hour, once a day. The nursing staff can print the report, but the nurse assigned to the patient primarily prints it or it is set up to automatically print at a specific hour. Printing the PCA Infusion Form is mandatory, unless otherwise specified by hospital policy. The report is usually a permanent part of the patient's chart.

38.1 How to Print

The PCA Infusion Form may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

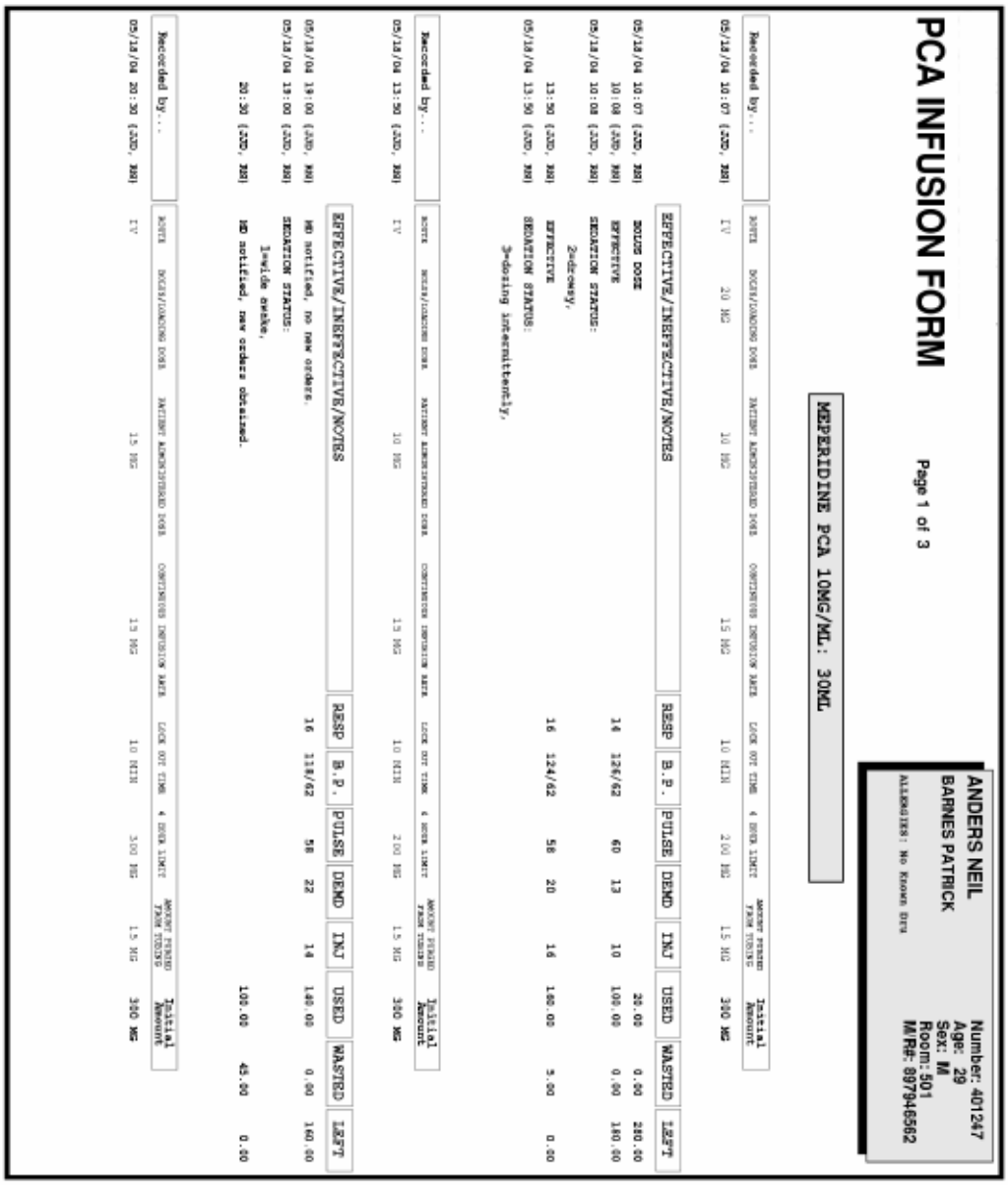
1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart select the appropriate tab.
3. Select **PCA Infusion Form.**

38.2 Description and Usage

The PCA Infusion Form is a cumulative document that includes the patient's PCA administration chart and assessment from the beginning of stay.

PCA Infusion Form

PCA Infusion Form



PCA INFUSION FORM

Page 1 of 3

ANDERS NEIL
BARNES PATRICK
ALLERGIES: No Known Drg

Number: 401247
Age: 29
Sex: M
Room: 501
MR#: 897946562

MEPERIDINE PCA 10MG/ML: 30ML

Recorded by...	ROUTE	DOSE/CONCORD DOSE	PATIENT ADMINISTERED DOSE	CONTINUOUS INFUSION RATE	LOCK OUT TIME	4 HOUR LIMIT	AMOUNT PENDED FROM TUBING	Initial Amount
05/18/04 10:07 (JJD, RN)	IV	20 MG	10 MG	15 MG	10 MIN	200 MG	1.5 MG	300 MG

	EFFECTIVE/INEFFECTIVE/NOTES	RESP	B.P.	PULSE	DEMD	INJ	USED	WASTED	LEFT
05/18/04 10:07 (JJD, RN)	BOLUS DOSE						20.00	0.00	280.00
10:08 (JJD, RN)	EFFECTIVE	14	126/62	60	13	10	100.00	0.00	180.00
05/18/04 10:08 (JJD, RN)	SEDATION STATUS: 2=drowsy,								
13:50 (JJD, RN)	EFFECTIVE	16	124/62	58	20	16	180.00	5.00	0.00
05/18/04 13:50 (JJD, RN)	SEDATION STATUS: 3=dosing intermittently.								

Recorded by...	ROUTE	DOSE/CONCORD DOSE	PATIENT ADMINISTERED DOSE	CONTINUOUS INFUSION RATE	LOCK OUT TIME	4 HOUR LIMIT	AMOUNT PENDED FROM TUBING	Initial Amount
05/18/04 13:50 (JJD, RN)	IV	10 MG	10 MG	15 MG	10 MIN	200 MG	1.5 MG	300 MG

	EFFECTIVE/INEFFECTIVE/NOTES	RESP	B.P.	PULSE	DEMD	INJ	USED	WASTED	LEFT
05/18/04 19:00 (JJD, RN)	MD notified, no new orders.	16	118/62	58	22	14	140.00	0.00	140.00
05/18/04 19:00 (JJD, RN)	SEDATION STATUS: 1=wide awake,								
20:30 (JJD, RN)	MD notified, new orders obtained.						100.00	40.00	0.00

Recorded by...	ROUTE	DOSE/CONCORD DOSE	PATIENT ADMINISTERED DOSE	CONTINUOUS INFUSION RATE	LOCK OUT TIME	4 HOUR LIMIT	AMOUNT PENDED FROM TUBING	Initial Amount
05/18/04 20:30 (JJD, RN)	IV	15 MG	15 MG	10 MIN	300 MG	1.5 MG	300 MG	

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Displays patient's name, admitting physician, age, sex, room number, medical records number, and any drug allergies documented through the TruBridge EHR system.
- **Medication:** The PCA medication description will be highlighted in a gray box.
- **Protocol:** Displays date and time protocol was entered, name and title of person who entered it, route of PCA, bolus (loading) dose, patient administered dose, continuous infusion rate (optional), lock-out time, four-hour limit, amount purged from tube priming, and syringe amount.
- **Administration Record:** Displays date and time of the administration and name and title of person who entered it. If a medication was administered using the second witness option, the system will print the second employee's initials and time of medication administration in a bold font underneath the first employee's initials and time of medication administration. Will also display effective, ineffective, notes, respiration, blood pressure, pulse, number of demands, number of injections, amount wasted, and amount left.

Chapter 39 PC Backup

39.1 Overview

TruBridge has a backup system that stores Point of Care and Computerized Physician Order Entry (CPOE) documentation in the event that the TruBridge system should go down. This system is referred as PC Backup. Having PC Backup and Downtime procedures in place can ensure that the difficult transition to written documentation will be a smooth one.

PC Backup is solely used to store Point of Care and CPOE documentation. This device stores encrypted files on the hard drive of the PC that has been designated for PC Backup. The device executes a backup each hour, separate from the main TruBridge backup. This is a continuous process. It is recommended that each department have the Patient Progress Notes and the Medication Administration Record (MAR) set to spool to the PC Backup device. Spooling means that the system will download the information to the PC Backup's hard drive for storage. The CPOE backup component will include orders that physicians have placed electronically.

If the system fails, the following protocols should be implemented as soon as possible to ensure the continuum of documentation.

- Print off information from the PC Backup. You will have the ability of choosing which "backup time" you would like to print. The documentation has been "spooled" every hour to the PC for easy retrieval. When you select the file to print you will be prompted for your PC Backup password in order to view the documentation.

- Reports that are usually designated to spool automatically include:
  - Patient Progress Notes
  - Medication Administration Record (MAR)

- The CPOE order report will contain orders that have been placed by physicians.

39.2 General Information

- PC Backup is used for Point of Care and ChartLink documentation. In addition, Backup Reports by Department is used to set up the Documentation Reports that will be spooled to the PC Backup for any departments that use Documentation. Any Documentation Report set up in this table will pull in PDF format and include any Documentation entered over the course of the last 24 hours. It will be sent to the PC Backup every hour on the half hour.

- PC Backup is separate from the main backup of the TruBridge system.

- PC Backup stores encrypted files on the hard drive of the PC designated for PC Backup.

- In order to view the files stored on the PC Backup you must have a PC Backup password. For more information on creating or changing the PC Backup password, please reference the System Administration User Guide.

- The device executes a back up each hour, storing up to 7 days of information. After the PC Backup has stored the last hour of information based on the amount of information to be stored, the oldest hour will be replaced by the current hour. This is a continuous process.

- This enables your facility to print nursing documentation and CPOE orders if the system should go down unexpectedly. Reports will be available for printing on the current patient index. This is useful in that staff can print hard copies of the record, rather than hand writing them if there should be a problem with the system.

- The primary sort of the patient information that is available via PC Backup is by department. CPOE orders are grouped by individual patient.

- Because this is a backup device, it is recommended this device and printer be connected to a red (generator) plug in case of a power outage. It is also recommended that any hibernation mode be turned off for the PC Backup device.

- It is recommended that the PC Backup PC have the most current version of Clientware.

- It is recommended that each department have the Patient Progress Notes and the Medication Administration Record (MAR) set to spool to the device. In addition to the Progress Notes, other reports are available for spooling as well (if desired). However, facilities should be selective regarding the reports that they set to spool to the PC Backup device because the number of selected reports may influence the speed of the PC Backup. CPOE orders do not have a setting. They spool automatically.

- Point of Care Reports that can be set to spool to PC Backup are:
  - 24hr Summary
  - Diabetic Flow Sheet
  - Discharge Planner
  - Discharge Summary
  - Education
  - Floor Stock
  - Graphic I & O
  - Initial Interview
  - Initial Physical Assessment
  - MAR
  - Medication Record
  - Pain Flowsheet
  - Patient Progress Notes
  - Patient Summary
  - PCA Infusion Form
  - Problem List
  - Shift Summary
  - Swan Ganz
  - Vital Signs Bar Graph

***NOTE**: Please remember that facilities should be selective regarding the reports that they set to spool to the PC Backup device, because the number of selected reports may influence the speed of the PC Backup. TruBridge recommends that the Patient Progress Notes and Medication Administration Record be setup in this manner as the combination of these two reports should provide most of the information needed for patient care.*

***NOTE**: Backup Reports by Department is used to set up the Documentation Reports that will be spooled to the PC Backup for any departments that use Documentation. Any Documentation Report set up in this table will pull in PDF format and include any documentation entered over the course of the last 24 hours. It will be sent to the PC Backup every hour on the half hour*

39.3 Maintenance of PC Backup

- PC Backup should be checked each shift, either at the end or beginning of the shift. Your facility can determine which works best.
- Your facility may choose to assign a specific employee to handle this task. The Charge Nurse, Supervisor, or Unit Secretary is the typical candidate.
- Be sure the employees who handle this task have access to the PC Backup password, required to view or print documentation.
- There is a log that should be kept next to the PC Backup, allowing the designated person to sign-off for their shift, confirming that PC Backup was checked and is functioning properly.
- To check PC Backup, the assigned employee will check the screen of PC Backup to assure that times are showing each hour. This assures that the system is backing up properly. If there are times missing, the assigned employee should follow the chain-of-command in calling a situation to TruBridge.
- In order to print out notes from PC Backup, an assigned employee can click on one of the times they wish to view or print. Once the specific time is selected, PC Backup will give them a choice to view or print.
- It is recommended that the device used for PC Backup be used solely for its intended purpose.

Chapter 40 Physician Census

The Physician Census is a document that provides a physician with a concise listing of the patients for whom he is attending or consulting, as well as the patient's most recent vital signs. It can be printed at anytime during the patient's stay, but it is primarily printed for physician rounds. The nursing staff or physicians can print the report. Printing the Physician Census is optional, unless otherwise specified by hospital policy. The report is usually not a permanent part of the patient's chart and can be discarded after use.

40.1 How to Print

The Physician Census may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

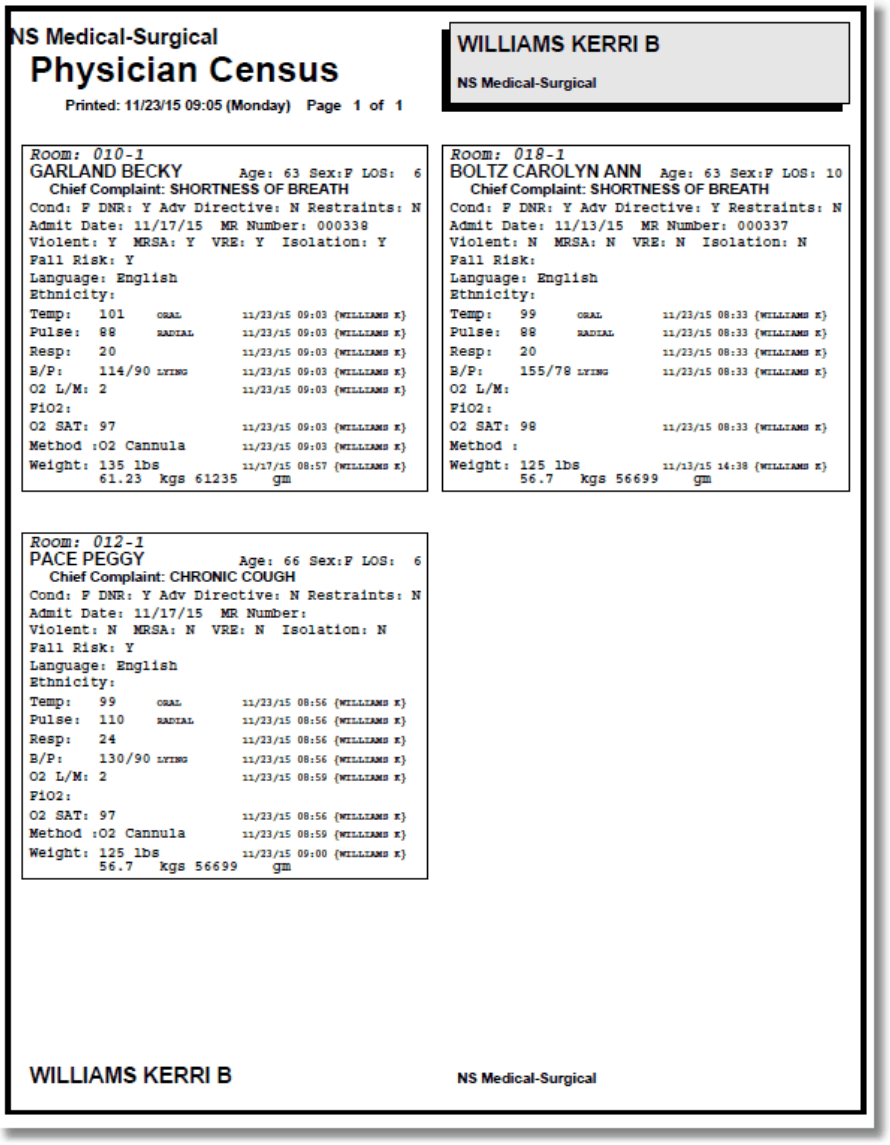
1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart select the appropriate tab.
3. Select **Patient Census**.
4. Select a physician by checking "All Physicians" and typing in a physician's name or select a physician from the list.
5. Select a physician name and then "Add Selected" to add physician to Physician Selection List
6. The Physician Census can be processed for "Your Dept Only" or "All Depts" by selecting the appropriate radio button.
7. Select **Process.**

   System prompts "Enter Number of Copies to Print"
8. Enter the number of reports to print.
9. Select **OK**.

40.2 Description and Usage

The Physician Census is a document that provides a physician with a concise listing of the patients for whom he is attending or consulting, as well as the patient's most recent vital signs. (Although the Physician Census includes some of the same information as the Physician Rounds Sheet, the Physician Rounds Sheet can still be printed through the Nursing Department, Hospital Base menu-X-g.)

Physician Census



NS Medical-Surgical

Physician Census

Printed: 11/23/15 09:05 (Monday) Page 1 of 1

WILLIAMS KERRI B

NS Medical-Surgical

Room: 010-1
GARLAND BECKY Age: 63 Sex:F LOS: 6
Chief Complaint: SHORTNESS OF BREATH
Cond: F DNR: Y Adv Directive: N Restraints: N
Admit Date: 11/17/15 MR Number: 000338
Violent: Y MRSA: Y VRE: Y Isolation: Y
Fall Risk: Y
Language: English
Ethnicity:

Temp:	101	ORAL	11/23/15 09:03 {WILLIAMS K}
Pulse:	88	RADIAL	11/23/15 09:03 {WILLIAMS K}
Resp:	20		11/23/15 09:03 {WILLIAMS K}
B/P:	114/90	LYING	11/23/15 09:03 {WILLIAMS K}
O2 L/M:	2		11/23/15 09:03 {WILLIAMS K}
FiO2:			
O2 SAT:	97		11/23/15 09:03 {WILLIAMS K}
Method :	O2 Cannula		11/23/15 09:03 {WILLIAMS K}
Weight:	135 lbs 61.23 kgs 61235 gm		11/17/15 08:57 {WILLIAMS K}

Room: 018-1
BOLTZ CAROLYN ANN Age: 63 Sex:F LOS: 10
Chief Complaint: SHORTNESS OF BREATH
Cond: F DNR: Y Adv Directive: Y Restraints: N
Admit Date: 11/13/15 MR Number: 000337
Violent: N MRSA: N VRE: N Isolation: N
Fall Risk:
Language: English
Ethnicity:

Temp:	99	ORAL	11/23/15 08:33 {WILLIAMS K}
Pulse:	88	RADIAL	11/23/15 08:33 {WILLIAMS K}
Resp:	20		11/23/15 08:33 {WILLIAMS K}
B/P:	155/78	LYING	11/23/15 08:33 {WILLIAMS K}
O2 L/M:			
FiO2:			
O2 SAT:	98		11/23/15 08:33 {WILLIAMS K}
Method :			
Weight:	125 lbs 56.7 kgs 56699 gm		11/13/15 14:38 {WILLIAMS K}

Room: 012-1
PACE PEGGY Age: 66 Sex:F LOS: 6
Chief Complaint: CHRONIC COUGH
Cond: F DNR: Y Adv Directive: N Restraints: N
Admit Date: 11/17/15 MR Number:
Violent: N MRSA: N VRE: N Isolation: N
Fall Risk: Y
Language: English
Ethnicity:

Temp:	99	ORAL	11/23/15 08:56 {WILLIAMS K}
Pulse:	110	RADIAL	11/23/15 08:56 {WILLIAMS K}
Resp:	24		11/23/15 08:56 {WILLIAMS K}
B/P:	130/90	LYING	11/23/15 08:56 {WILLIAMS K}
O2 L/M:	2		11/23/15 08:59 {WILLIAMS K}
FiO2:			
O2 SAT:	97		11/23/15 08:56 {WILLIAMS K}
Method :	O2 Cannula		11/23/15 08:59 {WILLIAMS K}
Weight:	125 lbs 56.7 kgs 56699 gm		11/23/15 09:00 {WILLIAMS K}

WILLIAMS KERRI B NS Medical-Surgical

Listed below is an explanation of each column.

- **Physician Name Box (located upper right-hand corner):** Displays the physician's name and the name of the nursing unit. This information is duplicated along the bottom edge of the report as well.

- **Patient Information:** A list of up to eight patients per page for whom the physician is either attending or consulting is reflected in separate boxes and includes the following information:
  - Patient room number
  - Admitting Physician
  - Patient name, age, sex, and length of stay
  - Chief Complaint
  - Medical Record Number
  - Most recent set of vital signs:
  - Temperature (including site)
  - Pulse (including site)
  - Respiration
  - Blood pressure (including posture and extremity)
  - O2, O2 L/Min, FiO2, and O2 Sat
  - Most recent weight
  - Date and time the vitals were charted
  - Name and title of the person who charted the vitals
  - Isolation
  - Fall Risk
  - Language
  - Ethnicity

NOTE: *Patients, for whom a physician is consulting, are highlighted in a gray box. The attending physician's name is indicated at the top of the box.*

Chapter 41 Physician Order Report

The Medication portion of the Physician Order Sheet is a document that includes all ordered medications for an individual patient. The Nursing Orders portion of the Physician Order Sheet report is a document that includes the patient's verified nursing orders. It can be printed at anytime during the patient's stay, but it is primarily printed for the physicians to continue or discontinue orders on a patient transferring within the facility. Printing the Physician Order Sheet report is optional, unless otherwise specified by hospital policy. The report is commonly not a permanent part of the patient's chart and can be discarded after use.

41.1 How to Print

The Physician Order Report may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.

2. From the Virtual Chart select the appropriate tab.

3. Select **Physician Order Report**.

System Prompts, "Physician Order Report Options"
Medications
Nursing Orders
Both

If **Medications** is selected:
A. Physician's Medications Report prints.

If **Nursing Orders** is selected:
A. Physician's Nursing Orders Report prints.

If **Both** is selected:
A. Physician's Medications Report and Physician's Nursing Orders Report print separately.

41.2 Description and Usage

The Medication portion of the Physician Order Sheet is a document that includes all ordered medications for an individual patient. Also it includes the option to select either continue or discontinue the medications.

The Nursing Orders portion of the Physician Order Sheet report is a document that includes the patient's verified nursing orders. It can be used by physicians to continue or discontinue orders on a transferring patient.

Physician Order Report

Medication Physician Order Sheet

Medication Report Page 1 of 1
From beginning of stay

BOLTZ CAROLYN
ADM PHY : ROGERS RYAN L
CON PHY: BAXTER JAMES D
ALLERGIES: Penic Codeine
DIAGNOSIS: CHEST PAIN NOS

Number: 356959
Age: 60
Sex: F
Room: 500
M/R#: 235689

DIGOXIN TAB HOLD FOR PULSE < 56	0.125 MG	EVERY DAY	ORAL CONT	DISCONTINUE
TYLENOL TAB FOR TEMP < 101.5	325 MG	PRN Q6H	ORAL CONT	DISCONTINUE
COUMADIN (WARFARIN) TAB HOLD FOR INR > 2.0	5 MG	EVERY DAY	ORAL CONT	DISCONTINUE
CEPHALEXIN (CEPHALEXIN) CP TAKE 1 TABLET BY MOUTH 4 TIMES A DAY	250 MG	QID	ORAL CONT	DISCONTINUE

Date:_____ Time:_____ Signature:_____

Medical Order Physician Order Sheet

MEDICAL ORDERS

Printed 5/13/05 at 16:32 Page 1 of 1

BOLTZ CAROLYN
ROGERS RYAN L
ALLERGIES: Penic Codeine
AGE: 60
SEX: F
ROOM: 500
M/R#: 235689

VITAL SIGNS Q SHIFT	☐ CONT	☐ DISCONTINUE
DAILY WEIGHTS	☐ CONT	☐ DISCONTINUE
I&O Q SHIFT	☐ CONT	☐ DISCONTINUE
UP IN CHAIR X _3___	☐ CONT	☐ DISCONTINUE
AMBULATE WITH ASSISTANCE	☐ CONT	☐ DISCONTINUE
ACCUCHECKS 0700/1100/1600/2100 {CHART RESULTS ON DIABETIC RECORD}	☐ CONT	☐ DISCONTINUE
ASSISTED BATH	☐ CONT	☐ DISCONTINUE

Date:_____ Time:_____ Signature:_____

PATIENT:	BOLTZ CAROLYN	NUMBER:	356959	AGE:	60	SEX:	F	ROOM:	500	PAGE:	1

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Displays patient's name, admitting physician, age, sex, room number, medical records number, and any drug allergies documented through the TruBridge EHR system. In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number, and page number will appear along the bottom edge of the page.

- **Patient Information:** Displays patient's name, room number, age, sex, admitting physician, consulting physician, and any drug allergies documented through the TruBridge EHR system.

- **Medication Information:** Displays medication description, dosage, frequency, route, instructions, start/stop information, flow rate and components on IV piggybacks, and the option to continue or discontinue the medication.

- **Omission Information:** Displays the date, time, and reason medication was omitted.

- **Administration Record:** Displays the date/time, nurse, dose/unit, site, and comments/reason.

***NOTE**: The Physician Order Report automatically prints when verbal and telephone orders are placed from Point of Care. Once the user places orders and then exits the order entry box, a print dialog box with the default printer number will pop up and the 'Physician Order Report' will print with the verbal and telephone order(s) that were just placed. The users will still have the option to reprint the Physician Order Report from the Hospital Base Menu and Point of Care Whiteboard.*

Chapter 42 Problem Activity Report

The Problem Activity report is a document that includes the patient's identified problems and goals and all activity charted on each. It displays the path of progression toward resolution from the beginning of stay. It can be printed at anytime during the patient's stay by the nursing staff, but the nurse assigned to the patient primarily prints it. Printing the Problem Activity report is optional, unless otherwise specified by hospital policy. The report is usually not a permanent part of the patient's chart.

42.1 How to Print

The Problem Activity Report may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart select the appropriate tab.
3. Select **Problem Activity Report.**

   System prompts "Include stricken/amended data?"
4. This option will include stricken/amended data in the report.
5. To print,select a problem and click add selected to add the problem to the Problem List to Print.
6. Select Process**.**

   System prompts "Print Problem Activity"
7. This allows the report to be printed by shift or from the beginning of the patient's stay

Chapter 43 Problem List

The Problem List is a document that includes the patient's identified problems and goals and the current status of each. It can be printed at anytime during the patient's stay by the nursing staff, but the nurse assigned to the patient primarily prints it. Printing the Problem List is optional, unless otherwise specified by hospital policy. The report is usually not a permanent part of the patient's chart.

43.1 How to Print

The Problem List Report may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart select the appropriate tab.
3. Select **Problem List Report**.
4. Select a patient by choosing "This Department", "My Patients", or "Current Patients."
5. Click patient name and then "Add Selected" to add patient to Patient Selection List
6. Select **Process**.

43.2 Description and Usage

The Problem List is a document that includes the patient's identified problems and goals and the current status of each. It can be used by nurses as a reference for the latest activity charted without having to review the Patient Progress Notes.

Problem List

Problem List

PROBLEM LIST

Printed 3/20/00 at 08:04 Page 1 of 1

BOLTZ CAROLYN
SHAPIRO VICKI
ALLERGIES: Penicillin Bactrim
AGE: 79
SEX: F
ROOM: TS001
M/R#: 012345

PROBLEM 0 Knowledge Deficit R/T Disease Process

Intervention 03/20/00 0754 (DOE, RN)

*** Instruct Patient on S/S of Disease Process ie. SOB/EDEMA/CP**

Will continue to reinforce teaching throughout admission.

Addressed 03/20/00 0753 (DOE, RN)

*** Reinforce Importance of Keeping Follow-up Dr. Appt after Discharge.**

Appt made by JSD, RN. REminder given to Pt.

Resolved 03/20/00 0752 (DOE, RN)

*** Provide Information Regarding Community Resources.**

Pamphlets provided for Patient/Family.

Resolved 03/20/00 0748 (DOE, RN)

PROBLEM 0 Impaired Gas Exchange

Evaluation 03/20/00 0759 (DOE, RN)

*** Provide Comfort to Reduce Fear and Anxiety**

Demonstrated comfort measures for Pt/SO.

Addressed 03/20/00 0757 (DOE, RN)

*** Maintain High Fowlers Position**

Met 03/20/00 0757 (DOE, RN)

*** N.T. Suction if Secretions not Cleared by Cough**

No N.T. Suctioning required at this time.

Addressed 03/20/00 0758 (DOE, RN)

PATIENT:	BOLTZ CAROLYN	NUMBER:	100982	AGE:	79	SEX:	F	ROOM:	TS001	PAGE:	1

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Displays patient's name, admitting physician, age, sex, room number, medical record number, and any drug allergies documented through the TruBridge EHR system. In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number, and page number will appear along the bottom edge of the page.

- **Problem List Box:** Shaded in gray, each box contains one problem order of up to 75 characters.

- **Problem List Activity:** Displays last action taken to the problem and any comment that was added. Next to the action it will display the date, time, and name of person entering the information. Below the Problem and Action to the problem the goals related to that problem will be listed in order of entry and will be preceded with an asterisk. Below all goals, report will display last action taken and any comments. Next to all goals it will display the date, time, and name of person entering the information

- **Problem List Status:** The status indicates the last action taken on the problem and will appear directly below the comment. The date and time will indicate the last time the problem was charted on and will display the name and title of the person who charted on the problem or goals.

- **Additional Notes:** Displays problems that have been resolved will display on this report.

Chapter 44 Scheduled Medication Report

The Scheduled Medication Report is a document that includes all of the current scheduled medications for an eight-hour time period for an individual patient or group of patients. It can be printed at anytime during the patient's stay, but it is primarily printed for the nurses as a worksheet at the beginning of each shift. The nursing staff can print the report, but the nurse assigned to the patient primarily prints it. Printing the Scheduled Medication Report is optional, unless otherwise specified by hospital policy. The report is usually not a permanent part of the patient's chart and can be discarded after use.

44.1 How to Print

The Scheduled Medications Report may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart select the appropriate tab.
3. Select **Scheduled Med Report**.
4. Select a patient by choosing "This Department", "My Patients", or "Current Patients."
5. Click patient name and then "Add Selected" to add patient to Patient Selection List
6. Select **Process**.

   System prompts "Select Time Range for the Scheduled Medication Report"
7. Select the shift times that the report is needed
8. Select **Print**.

44.2 Description and Usage

The Scheduled Medication Report is a document that includes all of the current scheduled medications for an eight-hour time period for an individual patient or group of patients. This report can be used as a worksheet by nursing at the beginning of the shift to conduct an organized and timely routine for administering medications. PRNs and large volume IVs do not print on the report.

Scheduled Medication Report

Scheduled Medication Report

Scheduled Medication Report

RUN: 06/01/05 @ 08:42

FROM: 06/01/05 07:00 TO: 06/01/05 15:00 PAGE: 1 of 1

BOLTZ CAROLYN NUM: 356959 ROOM: 202-2 AGE: 56 SEX: F Admitting Physician: JAMES BAXTER, MD

ALLERGIES: Penicillin Sulfamide Haldol

Omission Information 7 8 9 10 11 12 13 14

DIAGNOSIS: CHEST PAIN NOS

LANOXIN TEST TAB 0.125 MG	DAILY	PO	CHECK 09:00	09	
CA ASPIRIN 325MG 325 MG TAKE ONCE PER DAY	DAILY	PO	CHECK 09:00	09	
GLIPIZIDE (GLIPIZIDE) TB 10 MG	DAILY	PO	CHECK 09:00	09	
DIPHENHYDRAMINE CAP 25 MG	QHS	PO	CHECK 02:00		
COUMADIN (WARFARIN) 5 MG HOLD FOR INR > 2.5	DAILY	PO	CHECK 13:00		13
DIPHENHYDRAMINE CAP 25 MG	*BID	PO	CHECK 21:00	09	

ANCEF 1GM/NS 50ML 100 ml/hr Q8H NS ORDER 14 19

1 GM 50 ML ANCEF (CEFAZOLIN) SODIUM (SODIUM)

Listed below is an explanation of each column.

- **Patient Information:** Displays patient's name, patient's account number, room number, age, sex, admitting physician, and any drug allergies documented through the TruBridge EHR system.
- **Medication Information:** Displays medication description, dosage, frequency, instructions, "Unverified" if the medication has not been verified, flow rate, and components on IV Piggybacks.
- **Omission Information:** Displays date, time, and reason medication was omitted. Will also display the check time which indicates that a medication was not administered within thirty minutes before or 30 minutes after the scheduled time.
- **Administration Schedule:** An eight-hour time frame prints beside the Omission Information section. It indicates the scheduled time for each medication. A "G" displays below the appropriate time, indicating when the medication was given.

Chapter 45 Shift Summary Report

The Shift Summary Report is a document that includes all shift summary information that has been documented in the previous 24 hours of the patient's stay. It can be printed at anytime during the patient's stay by the nursing staff. Printing the Shift Summary Report is optional, unless otherwise specified by hospital policy. The report is usually not a permanent part of the patient's chart and can be discarded after use.

45.1 How to Print

The Shift Summary Report may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart select the appropriate tab.
3. Select **Shift Summary Report**.

   System prompts "Include stricken/amended data?"

4. This option will include any stricken or amended data in the report..
5. There are two options available; **Patient** or **Physician**. The **Patient** option allows the user to choose specified patient(s) and the **Physician** option allows the user to select patients by their attending physician.

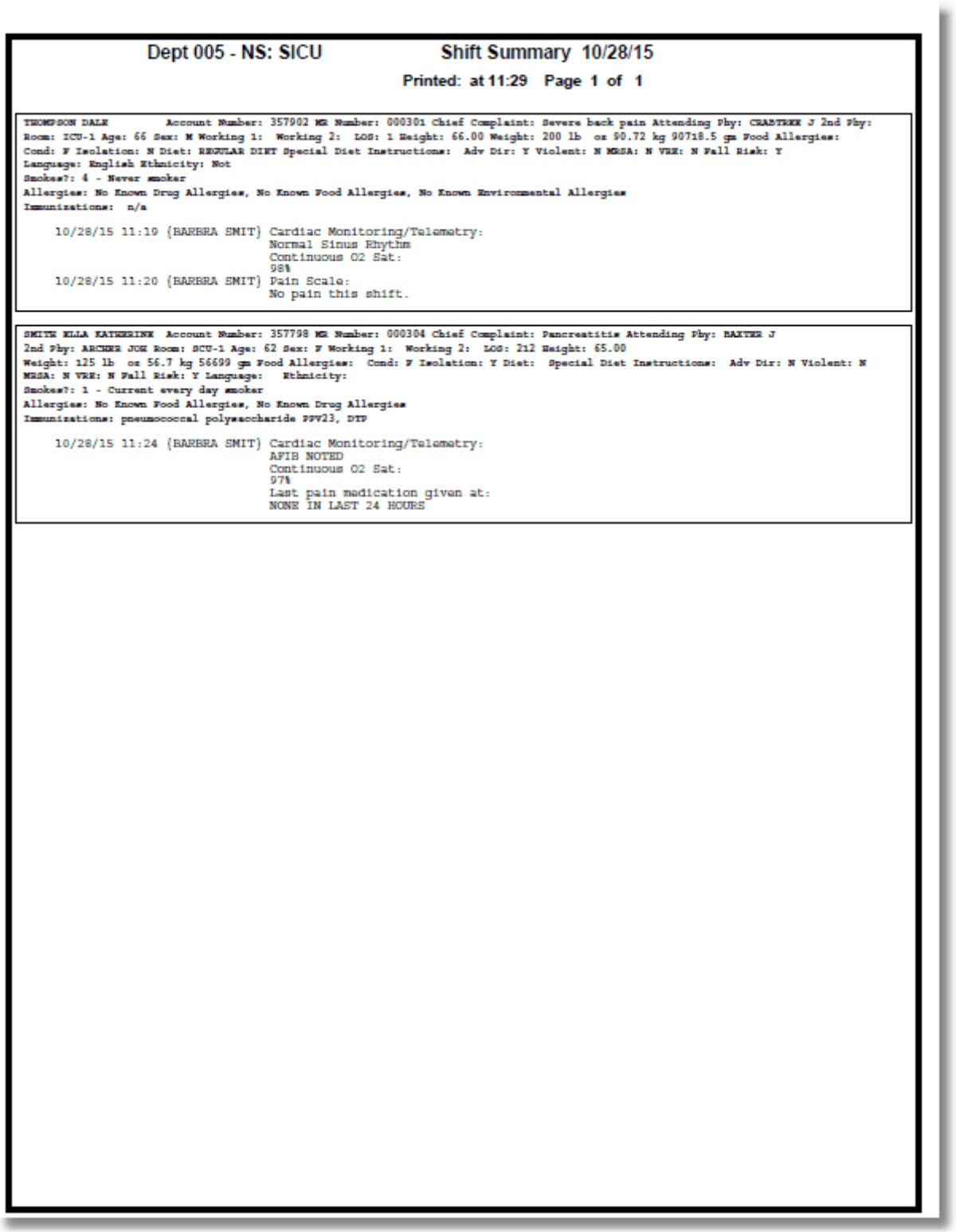
   System prompts "Enter Number of Copies to Print"

6. Enter the number of reports to print.

45.2 Description and Usage

The Shift Summary Report is a document that includes all shift summary information that has been documented in the previous 24 hours of the patient's stay.

Shift Summary Report



Dept 005 - NS: SICU Shift Summary 10/28/15

Printed: at 11:29 Page 1 of 1

THOMPSON DALE Account Number: 357902 MR Number: 000301 Chief Complaint: Severe back pain Attending Phy: CRABTREE J 2nd Phy:
Room: ICU-1 Age: 66 Sex: M Working 1: Working 2: LOS: 1 Height: 66.00 Weight: 200 lb oz 90.72 kg 90718.5 gm Food Allergies:
Cond: F Isolation: N Diet: REGULAR DIET Special Diet Instructions: Adv Dir: Y Violent: N MRSA: N VRE: N Fall Risk: Y
Language: English Ethnicity: Not
Smoker?: 4 - Never smoker
Allergies: No Known Drug Allergies, No Known Food Allergies, No Known Environmental Allergies
Immunizations: n/a

10/28/15 11:19 (BARBRA SMIT) Cardiac Monitoring/Telemetry:
Normal Sinus Rhythm
Continuous O2 Sat:
98%
10/28/15 11:20 (BARBRA SMIT) Pain Scale:
No pain this shift.

SMITH KLLA KATHERINE Account Number: 357798 MR Number: 000304 Chief Complaint: Pancreatitis Attending Phy: BAXTER J
2nd Phy: ARCHER JOE Room: SCU-1 Age: 62 Sex: F Working 1: Working 2: LOS: 212 Height: 65.00
Weight: 125 lb oz 56.7 kg 56699 gm Food Allergies: Cond: F Isolation: Y Diet: Special Diet Instructions: Adv Dir: N Violent: N
MRSA: N VRE: N Fall Risk: Y Language: Ethnicity:
Smoker?: 1 - Current every day smoker
Allergies: No Known Food Allergies, No Known Drug Allergies
Immunizations: pneumococcal polysaccharide PPV23, DTP

10/28/15 11:24 (BARBRA SMIT) Cardiac Monitoring/Telemetry:
AFIB NOTED
Continuous O2 Sat:
97%
Last pain medication given at:
NONE IN LAST 24 HOURS

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Displays the following:
  - Patient's name
  - Account Number
  - Medical Record Number
  - Sex
  - Condition Code
  - Diet
  - Admitting Physician
  - Second Physician
  - Chief Complaint
  - Working Diagnosis 1
  - Working Diagnosis 2
  - Length of stay
  - Patient account number
  - Age, sex, & room number
  - Medical Record number
  - Any drug/food allergies documented through the TruBridge EHR system
  - Advanced Directive
  - Smoking Status
  - Isolation Status
  - Fall Risk
  - Language
  - Ethnicity
  - Immunizations

- **Entries:** Displays all shift summary information charted the previous 24 hours through Point of Care.

Chapter 46 Swan Ganz

The Swan Ganz report is a document that includes hemodynamics (CVP, PAP, PAWP, CO, MPAP, SV, SVR, PVR, and CI). It can be printed at anytime during the patient's stay. The nursing staff can print the report, but the nurse assigned to the patient primarily prints it. Printing the Swan Ganz report is optional, unless otherwise specified by hospital policy. The report is usually not a permanent part of the patient's chart.

46.1 How to Print

The Swan Ganz may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart select the appropriate tab.
3. Select **Swan Ganz**.

46.2 Description and Usage

The Swan Ganz report is a document that includes hemodynamics (CVP, PAP, PAWP, CO, MPAP, SV, SVR, PVR, and CI).

Swan Ganz

Swanz Ganz

Page 1 of 1

SWAN GANZ

From beginning of stay TO: 03/06/00 14:39

WALSH KIERAN
SHAPIRO VICKI
ALLERGIES: Bactrim Penicillin
AGE: 49
SEX: M
ROOM: TS002
M/R#: 012345

			CVP	PAP	PAWP	CO	MPAP	MAP	SV	SVR	PVR	CI
03/05/00	08:05	(JND, RN)	10.0	31/17	14	4.00	22	111	44	2020	160	1.9
	09:10		10.0	30/16	14	4.10	22	111	46	1971	137	2.0
	12:02		10.0	32/18	14	3.80	23	111	42	2126	189	1.8
	16:15		9.0	32/17	12	4.20	22	111	47	1943	190	2.0
	17:15		11.0	29/15	14	4.00	22	111	44	2020	140	1.9
	18:00		10.0	29/15	12	3.80	22	111	42	2126	147	1.8
	19:59		11.0	31/16	12	3.90	21	111	43	2051	185	1.9
	20:06	(AMJ, RN)	11.0	32/18	14	4.00	22	111	44	2020	140	1.9
	21:10		12.0	28/14	16	4.80	22	111	53	1683	117	2.3
	23:00		10.0	28/15	11	3.90	22	111	43	2072	144	1.9
03/06/00	00:25		9.0	30/15	11	3.80	20	111	42	2147	189	1.8
	01:05		9.0	31/16	11	4.00	22	111	44	2020	140	1.9
	02:15		10.0	31/18	11	5.00	22	111	56	1616	112	2.4
	03:05		10.0	32/16	12	4.80	22	111	53	1683	117	2.3
	04:19		8.0	31/17	10	3.90	22	111	43	2113	246	1.9
	05:15		12.0	32/15	12	4.50	22	111	50	1796	124	2.2
	06:25		10.0	28/14	14	4.00	22	111	44	2020	140	1.9
	08:00	(JND, RN)	10.0	32/16	14	4.00	21	111	44	2020	140	1.9
	09:02		11.0	30/15	12	4.00	22	111	44	2020	140	1.9
	10:00		12.0	31/17	14	4.20	22	111	47	1924	133	2.0
	11:10		11.0	31/15	13	4.10	22	111	46	1971	137	2.0
	12:05		11.0	30/14	9	3.40	19	111	38	2353	235	1.6
	13:04		10.0	32/18	14	4.00	22	111	44	2020	140	1.9
	14:05		11.0	29/14	13	3.90	22	111	43	2072	144	1.9
	16:02		11.0	31/16	14	4.70	21	111	52	1702	119	2.3
	20:06	(AMJ, RN)	10.0	33/17	15	4.50	22	111	50	1796	124	2.2

PATIENT:	WALSH KIERAN	NUMBER:	100989	AGE:	49	SEX:	M	ROOM:	TS002	PAGE:	1

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Displays patient's name, admitting physician, age, sex, room number, medical record number, and any drug allergies documented through the TruBridge EHR system. In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

- **Entered Values:** Displays the date and time the information was charted, name and title of the person who entered the information displays next to the first entry only. Name and title will not display beside each entry made by that person. Will also display in columns, the following Swan Ganz values that have been entered into the system:
  - (CVP) Central Venous Pressure
  - (PAP) Pulmonary Artery Pressure
  - (PAWP) Pulmonary Artery Wedge Pressure
  - (CO) Cardiac Output

- **Calculated Values:** Displays in columns, the following calculated values which are derived from the charted Swan Ganz values:
  - (MPAP) Mean Pulmonary Artery Pressure
  - (MAP) Mean Arterial Pressure (will display even if Cardiac Output is not entered)
  - (SV) Stroke Volume
  - (SVR) Systemic Vascular Resistance
  - (PVR) Pulmonary Vascular Resistance
  - (CI) Cardiac Index

Chapter 47 Transfer Form

The Patient Transfer Form is a document that includes the patient’s demographics, transferring and receiving facilities, medical information, active pharmacy orders, transfer consent, request or refusal, and other information pertinent for the transfer process. It can be printed at anytime during the patient’s stay, but it is primarily printed at patient transfer from the hospital. The nursing staff can print the report, but the nurse assigned to the patient primarily prints it or staff who make modifications to the report. Printing the Patient Transfer Form is mandatory, unless otherwise specified by hospital policy. The report is usually a permanent part of the patient's chart.

47.1 How to Print

The Transfer Form Report may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart select the appropriate tab.
3. Select **Transfer Form Report**.

   System prompts "Include stricken/amended data?"

4. This option will include any stricken or amended data in the report.

   System prompts "Enter Number of Copies to Print"

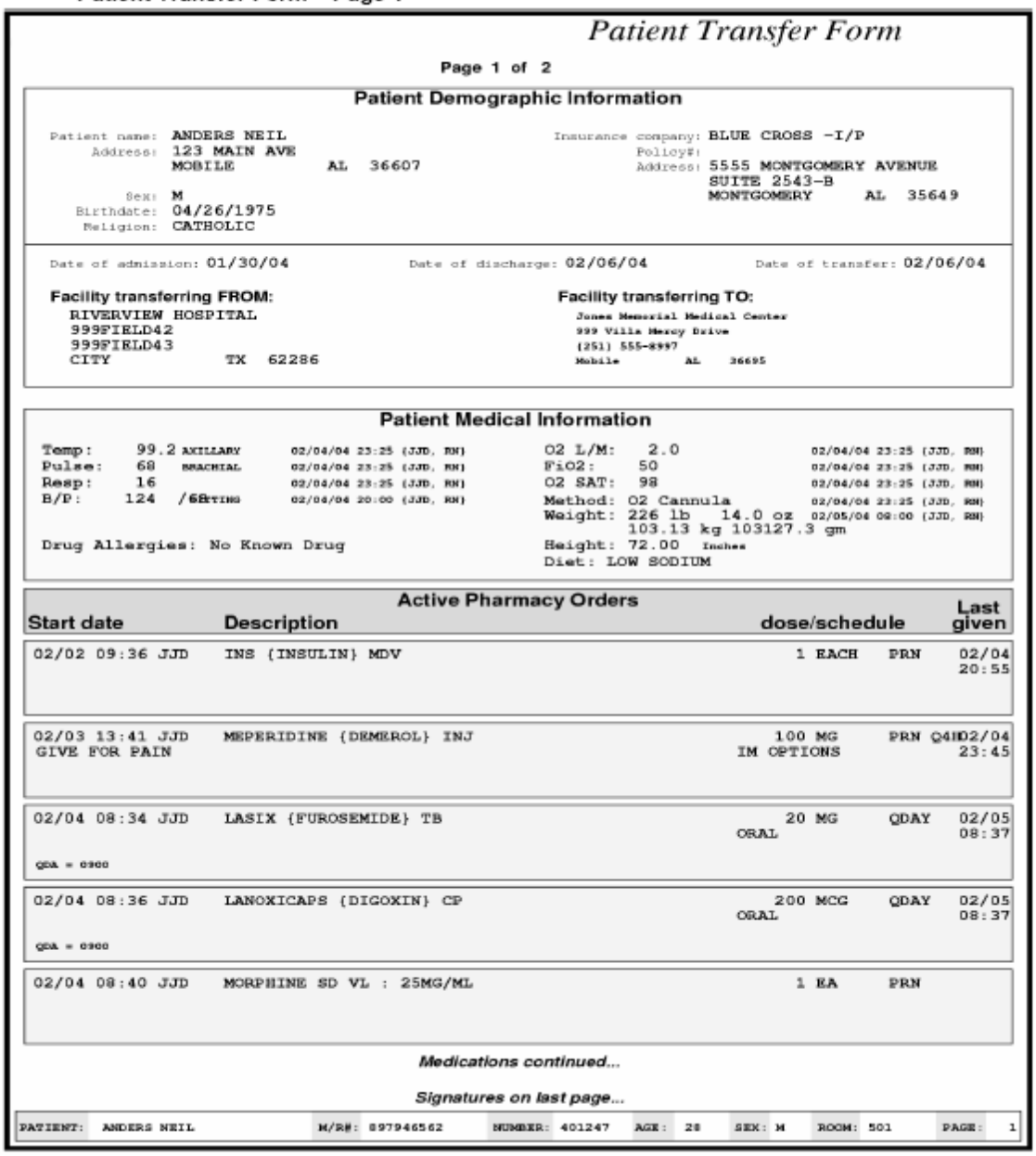
5. Enter the number of copies to print.
6. Select **OK**.

47.2 Description and Usage

The Patient Transfer Form is a document that includes the patient’s demographics, transferring and receiving facilities, medical information, active pharmacy orders, transfer consent, request or refusal, and other information pertinent for the transfer process.

Transfer Form - Page 1

Patient Transfer Form – Page 1



Patient Transfer Form

Page 1 of 2

Patient Demographic Information

Patient name: ANDERS NEIL
Address: 123 MAIN AVE
MOBILE AL 36607

Sex: M
Birthdate: 04/26/1975
Religion: CATHOLIC

Insurance company: BLUE CROSS -I/P
Policy#:
Address: 5555 MONTGOMERY AVENUE
SUITE 2543-B
MONTGOMERY AL 35649

Date of admission: 01/30/04 Date of discharge: 02/06/04 Date of transfer: 02/06/04

Facility transferring FROM:
RIVERVIEW HOSPITAL
999FIELD42
999FIELD43
CITY TX 62286

Facility transferring TO:
Jones Memorial Medical Center
999 Villa Mercy Drive
(251) 555-8997
Mobile AL 36695

Patient Medical Information

Temp:	99.2 AXILLARY	02/04/04 23:25 (JJD, RN)	
Pulse:	68 BRACHIAL	02/04/04 23:25 (JJD, RN)	
Resp:	16	02/04/04 23:25 (JJD, RN)	
B/P:	124 /68 SITTING	02/04/04 20:00 (JJD, RN)	
O2 L/M:	2.0	02/04/04 23:25 (JJD, RN)	
FiO2:	50	02/04/04 23:25 (JJD, RN)	
O2 SAT:	98	02/04/04 23:25 (JJD, RN)	
Method:	O2 Cannula	02/04/04 23:25 (JJD, RN)	
Weight:	226 lb 14.0 oz 103.13 kg 103127.3 gm	02/05/04 08:00 (JJD, RN)	
Height:	72.00 Inches		
Diet:	LOW SODIUM		

Drug Allergies: No Known Drug

Active Pharmacy Orders

Start date	Description	dose/schedule		Last given
02/02 09:36 JJD	INS {INSULIN} MDV	1 EACH	PRN	02/04 20:55
02/03 13:41 JJD GIVE FOR PAIN	MEPERIDINE {DEMEROL} INJ	100 MG IM OPTIONS	PRN Q4H	02/04 23:45
02/04 08:34 JJD QDA = 0900	LASIX {FUROSEMIDE} TB	20 MG ORAL	QDAY	02/05 08:37
02/04 08:36 JJD QDA = 0900	LANOXICAPS {DIGOXIN} CP	200 MCG ORAL	QDAY	02/05 08:37
02/04 08:40 JJD	MORPHINE SD VL : 25MG/ML	1 EA	PRN	

Medications continued...

Signatures on last page...

PATIENT: ANDERS NEIL M/R#: 897946562 NUMBER: 401247 AGE: 28 SEX: M ROOM: 501 PAGE: 1

Transfer Form - Page 2

Patient Transfer Form – Page 2

Patient Transfer Form

Page 2 of 2

Active Pharmacy Orders

Start date	Description		dose/schedule	Last given
02/04 09:00 JJD	D5 NS 1000ML	100 ml/hr	CONT	
CON =				
02/04 09:00 JJD	ANCEF 1GM/50ML D5W INFUSE OVER 30 MINUTES	100 ml/hr	*Q8	
*Q8 = 8 Hours between doses				

REASON FOR TRANSFER: Needs Critical Care Management.
SPECIAL PROCEDURES SCHEDULED AT TRANSFER FACILITY: Cardiac Cath, Hemodialysis.
METHOD OF TRANSPORTATION: Ambulance.
ATTENDANCE DURING TRANSPORT: EMT, Family.
EQUIPMENT REQUIRED FOR TRANSPORT: Oxygen, Pulse Oximetry.
ACCEPTING PHYSICIAN: DR. JONES
NOTIFIED BY: DR. STEPHENS
STATUS: Stable.
IMPAIRMENTS Hearing.
AMBULATORY STATUS: With assistance.
PLAN OF CARE DURING TRANSFER: IV Pumps, Monitor, O2.
VALUABLES GIVEN TO: WIFE

Transfer consent

I acknowledge that my medical condition has been evaluated and explained to me by the Emergency Department physician and/or my attending physician who has recommended that I be transferred to the service of Dr. _JONES_____ at _JONES_MEMORIAL_____.
The potential benefits of such transfer, the potential risks associated with such transfer and the probable risks of not being transferred have been explained to me and I fully understand them. With this knowledge and understanding, I agree and consent to be transferred.

Signatures

Signature of physician or nurse:_____ Date:_____
Patient signature:_____ Date:_____
If patient unable to sign: Responsible person:_____ Relationship:_____
Witness signature:_____

PATIENT: ANDERS NEIL M/R#: 897946562 NUMBER: 401247 AGE: 28 SEX: M ROOM: 501 PAGE: 2

Listed below is an explanation of each column.

- **Patient Demographic Information:** Displays patient's name, address, sex, birth date, religion, insurance company, policy number, address, dates of admission, discharge, transfer, and facility transferring FROM and TO. In addition to the above mentioned information, a single line containing the patient's name, medical record number, account number, age, sex, room number and page number will appear along the bottom edge of the page.

- **Patient Medical Information:** Displays the most recent:

▪ Temperature	▪ Pulse	▪ Respirations
▪ Blood pressure	▪ Height and weight	▪ Diet
▪ O2 L/Min	▪ FiO2	▪ O2 Sat
▪ Pharmacy orders unless discontinued from the Pharmacy Department		

Chapter 48 Vital Sign Bar Graph

The Vital Signs Bar Graph is a document that displays the patient's temperature, pulse, respirations, and blood pressure in numeric and bar graph form. The vital signs are listed in chronological order. It can be printed at anytime during the patient's stay by the nursing staff. Printing the Vital Signs Bar Graph is optional, unless otherwise specified by hospital policy. The report is usually not a permanent part of the patient's chart.

48.1 How to Print

The Vital Sign Bar Graph may be viewed and printed from the Virtual Chart or sent directly to a printer using the Printing menu.

1. From the Patient Whiteboard, select a patient.
2. From the Virtual Chart select the appropriate tab.
3. Select Vital Sign Bar Graph.
4. Select a patient by choosing "This Department", "My Patients", or "Current Patients."
5. Click patient name and then "Add Selected" to add patient to Patient Selection List
6. Select **Process**.

   System prompts "Select Time Range for the Vital Signs Bar Graph Report"
7. Select the shift times that the report is needed
8. Select **Print**.

48.2 Description and Usage

The Vital Signs Bar Graph is a document that displays the patient's temperature, pulse, respirations, and blood pressure in numeric and bar graph form. The vital signs are listed in chronological order.

Vital Sign Bar Graph

Vital Signs Bar Graph

Vital Signs Bar Graph

From beginning of stay TO: 02/06/04 09:58 Page 1 of 2

ANDERS NEIL
F McKENZIE LANGOWRTHY II
ALLERGIES: No Known Drs

AGE: 28
SEX: M
ROOM: 501
M/R#: 897946562

Temperature

96 97 98 99 100 101 102 103 104 105 106

01/30/04 15:46 {JJD, RN}	TYMPANIC	100.2
02/03/04 08:47 {JJD, RN}	TYMPANIC	99.0
02/04/04 08:44 {JJD, RN}	TYMPANIC	99.4
02/04/04 15:18 {JJD, RN}	AXILLARY	99.5
02/04/04 23:25 {JJD, RN}	AXILLARY	99.2

Pulse

60 70 80 90 100 110 120 130 140 150 160

01/30/04 15:46 {JJD, RN}	BRACHIAL	70
02/03/04 08:47 {JJD, RN}	RADIAL	76
02/04/04 08:44 {JJD, RN}	BRACHIAL	83
02/04/04 11:14 {JJD, RN}	BRACHIAL	68
02/04/04 15:18 {JJD, RN}	BRACHIAL	70
02/04/04 20:00 {JJD, RN}	BRACHIAL	64
02/04/04 23:25 {JJD, RN}	BRACHIAL	68

Respiration

10 20 30 40 50 60

01/30/04 15:46 {JJD, RN}	16
02/03/04 08:47 {JJD, RN}	16
02/04/04 08:44 {JJD, RN}	18
02/04/04 11:14 {JJD, RN}	16
02/04/04 15:18 {JJD, RN}	16
02/04/04 15:22 {JJD, RN}	16
02/04/04 20:00 {JJD, RN}	16
02/04/04 23:25 {JJD, RN}	16

Blood Pressure

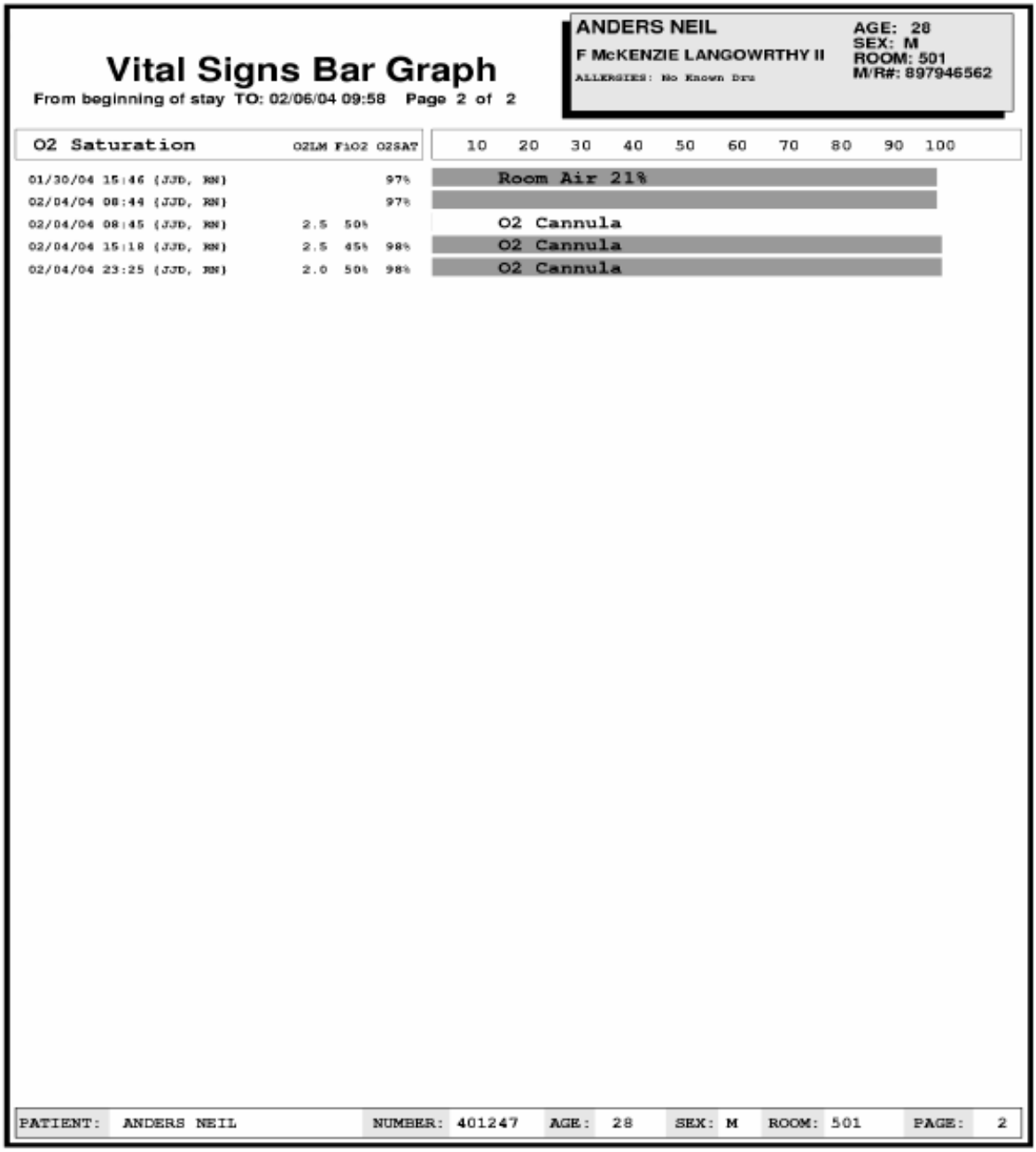
20 40 60 80 100 120 140 160 180 200

01/30/04 15:46 {JJD, RN}	SITTING	128	68
02/03/04 08:47 {JJD, RN}	LYING	130	78
02/04/04 08:44 {JJD, RN}	SITTING	130	81
02/04/04 11:14 {JJD, RN}	SITTING	126	67
02/04/04 15:18 {JJD, RN}	SITTING	134	70
02/04/04 20:00 {JJD, RN}	SITTING	124	68

PATIENT: ANDERS NEIL NUMBER: 401247 AGE: 28 SEX: M ROOM: 501 PAGE: 1

Vital Sign Bar Graph

Vital Signs Bar Graph



Vital Signs Bar Graph

From beginning of stay TO: 02/06/04 09:58 Page 2 of 2

ANDERS NEIL
F McKENZIE LANGOWRTHY II
ALLERGIES: No Known Drs

AGE: 28
SEX: M
ROOM: 501
M/R#: 897946562

O2 Saturation	O2LM	FiO2	O2SAT	10 20 30 40 50 60 70 80 90 100
01/30/04 15:46 (JJD, RN)			97%	Room Air 21%
02/04/04 08:44 (JJD, RN)			97%	
02/04/04 08:45 (JJD, RN)	2.5	50%		O2 Cannula
02/04/04 15:18 (JJD, RN)	2.5	45%	98%	O2 Cannula
02/04/04 23:25 (JJD, RN)	2.0	50%	98%	O2 Cannula

PATIENT: ANDERS NEIL NUMBER: 401247 AGE: 28 SEX: M ROOM: 501 PAGE: 2

Listed below is an explanation of each column.

- **Demographics Box (located upper right-hand corner):** Displays patient's name, admitting physician, age, sex, room number, medical records number, and any drug allergies documented through the TruBridge EHR system. In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

- **Temperature:** Displays numeric scale ranges from 96 - 106 degrees Fahrenheit, 33 - 43 degrees Centigrade, date and time each entry was charted, name and title of the person who charted each entry, and the site the temperature was taken: oral, rectal, tympanic, axillary or swan ganz. The value will be indicated numerically and then reflected on the bar graph.

- **Pulse:** Displays numeric scale ranges from 60 - 160, date and time each entry was charted, name and title of the person who charted each entry, and the method the pulse was taken: radial, brachial, femoral, carotid or "other" (The "other" option allows any additional method to be recorded, for example: apical). The value will be indicated numerically and then reflected on the bar graph.

- **Respiration:** Displays numeric scale ranges from 10 - 60, date and time each entry was charted, and the name and title of the person who charted each entry. The value charted will be indicated numerically and then reflected on the bar graph.

- **Blood Pressure:** Displays numeric scale ranges from 20 - 200 for diastolic and systolic, date and time each entry was charted, name and title of the person who charted each entry, position of patient while the blood pressure was taken: lying, sitting, standing, or doppler. The value charted will be indicated numerically and then reflected on the bar graph. On the Bar Graph note that the darker shade indicates the diastolic reading while the lighter shade indicates the systolic reading.

- **Oxygen:** Displays O2 L/Min, FiO2, and O2 Sat.